

# Long Term Care Community Services Waiver Programs Workshop

## Participant Guide



TEXAS MEDICAID & HEALTHCARE PARTNERSHIP  
A STATE MEDICAID CONTRACTOR



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# Objectives

Long Term Care (LTC) Community Services Waiver Programs workshop covers:

- Medicaid team roles.
- National Provider Identifier/Atypical Provider Identifier (NPI/API) requirements for transaction submission and billing.
- How to create an account for access to the Texas Medicaid & Healthcare Partnership (TMHP) LTC Online Portal.
- Basic portal features including Form Status Inquiry (FSI) and Current Activity.
- Printing completed and blank assessments.
- How to submit Medical Necessity and Level of Care (MN and LOC) Assessments.
- Definition of Medical Necessity (MN) and the MN Determination Process.
- The “Long Term Care Medicaid Information” (LTCMI) section, field by field.
- Correcting and inactivating assessments.
- How to check the status of assessments and resolve errors.
- The Texas State University Resource Utilization Group (RUG) training requirements and web address.
- How to report Medicaid Waste, Abuse and Fraud.
- *Health Insurance Portability and Accountability Act* (HIPAA) of 1996 Guidelines and Provider Responsibilities.
- Where to access additional resources.

# Medicaid Team

The roles and responsibilities of each of the Medicaid team members.

- **Centers for Medicare & Medicaid Services (CMS)** is the Federal Agency that oversees Medicaid on a Federal Level – Guidelines, Rules, and Regulations.
- **Texas Department of Aging and Disability Services (DADS)** administers a comprehensive array of services for persons who are aging and for persons who have Intellectual and Developmental Disabilities (IDD). Additionally, DADS licenses and regulates providers of these services.
- **Texas Health and Human Services Commission (HHSC)** oversees operations of the entire health and human services system in Texas. It operates the Medicaid acute care program, Children's Health Insurance Plan (CHIP), State of Texas Access Reform (STAR)+PLUS, and several other related programs. HHSC's Office of Eligibility Services (OES) determines eligibility for Medicaid.
- **Health Maintenance Organization (HMO)** is a State-contracted entity that has been given delegated authority to provide acute and long term services and support to enrolled managed care members.
- **Individuals** are those served by Texas Medicaid.
- **Providers** (including HMO's) are the crucial players in a quality health-care program. The focus is on providing the best care possible while being reimbursed for allowed services rendered.
- **Texas Medicaid & Healthcare Partnership (TMHP)** is contracted by the State as the claims administrator to process claims for providers under traditional Medicaid and Primary Care Case Management (PCCM). TMHP processes and approves claims for traditional Long Term Care (LTC). TMHP does not pay LTC claims; this is done by the comptroller. Responsibilities also include the following:
  - Determine Medical Necessity
  - Educate providers
  - Process claims in a timely manner (except for services covered by the STAR+PLUS premium)
  - Distribute yearly manuals, quarterly LTC Bulletins, and weekly Remittance and Status (R&S) Reports
  - Maintain the TMHP Call Center/Help Desk, Monday through Friday, 7:00 a.m. to 7:00 p.m., Central Time
  - Provide technical assistance to the online TexMedConnect application
- **Texas State Legislature** allocates budgetary dollars for Texas Medicaid.

# NPI Requirements

The *Health Insurance Portability and Accountability Act* (HIPAA) of 1996 established the NPI as the standard unique identifier for health-care providers and requires covered health-care providers, clearinghouses, and health plans to use this identifier in HIPAA-covered transactions.

NPI/API is a required field for MN and LOC Assessment submissions on the LTC Online Portal; therefore without an NPI/API, submissions are not allowed and will be rejected.

**Note:** DADS Medically Dependant Children Program (MDCP) Nurses are not required to apply for an NPI or API. The API is assigned by DADS.

## To Obtain an NPI

1. Go to <https://nppes.cms.hhs.gov/NPPES>
2. Click the **National Provider Identifier (NPI)** link to apply for an NPI.
3. Click the **Apply online for an NPI** link; the following page will display:

The screenshot shows the NPPES website interface. At the top left is the NPPES logo with the tagline "National Plan & Provider Enumeration System". At the top right are links for "Home" and "Help". The main heading is "NPI Application Instructions". Below this is a note about using browser buttons. The instructions are divided into two main sections: "Step 1: Before you begin, make sure you have the following information." and "Step 2: Read the information below." Step 1 includes a list of required information for individual providers and organizations, with asterisks indicating required fields. Step 2 includes contact information for the NPI Enumerator and a note about agreeing to terms.

**NPPES**  
National Plan & Provider Enumeration System

Home Help

### NPI Application Instructions

**Note:** Use of Back and Forward browser buttons could result in loss of all the information entered. Users should use the Next and Previous buttons provided on the application to navigate between the pages of the application.

**Step 1: Before you begin, make sure you have the following information.**  
This information will be required to complete the NPI Application Form.  
You will not be able to save your work if you quit before you have completed the application form.

- Information Required for Individual Providers**
  - Provider Name
  - \*\* SSN (or ITIN if not eligible for SSN)
  - Provider Date of Birth
  - Country of Birth
  - State of Birth (if Country of Birth is U.S.)
  - Provider Gender
  - Mailing Address
  - Practice Location Address and Phone Number
  - \*\*\* Taxonomy (Provider Type)
  - \* State License Information
  - Contact Person Name
  - Contact Person Phone Number and E-mail
- Information Required for Organizations**
  - Organization Name
  - \*\* Employer Identification Number (EIN)
  - Name of Authorized Official for the Organization
  - Phone Number of Authorized Official for the Organization
  - Organization Mailing Address
  - Practice Location Address and Phone Number
  - \*\*\* Taxonomy (Provider Type)
  - Contact Person Name
  - Contact Person Phone Number and E-mail

\* (required for certain taxonomies only)  
 \*\* (SSN or ITIN information should only be reported in the SSN or ITIN field)  
 \*\*\* Do not report an SSN or IRS ITIN in the EIN field  
 \*\*\* Provider Taxonomy codes can be obtained from <http://www.wpc-edi.com/taxonomy>

Online Help is available from each page of the Application / Update Form by clicking "Help" at the top right of the page.

If you need additional help or have any questions concerning your application, contact the NPI Enumerator.

**NPI Enumerator Contact Information**

By phone: 1-800-465-3203 (NPI Toll-Free)  
1-800-692-2326 (NPI TTY)

By e-mail at: [customerservice@npinenumerator.com](mailto:customerservice@npinenumerator.com)

By mail at:  
NPI Enumerator  
PO Box 6059  
Fargo, ND 58108-6059

**Step 2: Read the information below.**  
You must agree to the terms below when you submit your application:

4. Click the “Begin Application Form” button, located at the bottom of this screen:

Mailing Address  
Practice Location Address and Phone Number  
\*\*\*\* Taxonomy (Provider Type)  
\* State License Information  
Contact Person Name  
Contact Person Phone Number and E-mail

\*\*\*\* Taxonomy (Provider Type)  
Contact Person Name  
Contact Person Phone Number and E-mail

\* (required for certain taxonomies only)  
\*\* (SSN or ITIN information should only be reported in the SSN or ITIN field)  
\*\*\* Do not report an SSN or IRS ITIN in the EIN field  
\*\*\*\* Provider Taxonomy codes can be obtained from <http://www.wpc-edi.com/taxonomy>

Online Help is available from each page of the Application / Update Form by clicking “Help” at the top right of the page.

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By e-mail at: [customerservice@npienumerator.com](mailto:customerservice@npienumerator.com)

By mail at: NPI Enumerator  
PO Box 6059  
Fargo, ND 58108-6059

**Step 2: Read the information below.**  
You must agree to the terms below when you submit your application:

I have read the contents of the application and the information contained herein is true, correct, and complete. If I become aware that any information in this application is not true, correct, or complete, I agree to notify the NPI Enumerator immediately.

I authorize the NPI Enumerator to verify the information contained herein. I agree to keep the NPPES updated with any changes to data listed on this application form within 30 days of the effective date of the change.

I understand that the information provided in this application may be used by other agencies in accordance with privacy regulations.

I have read and understand the [Privacy Act Statement](#).

I have read and understand the [Penalties for Falsifying Information](#) on the NPI Application / Update Form as stated in this application. I am aware that falsifying information will result in fines and/or imprisonment.

**Penalties for Falsifying Information on the NPI / Update Form:**  
18 U.S.C. 1001 authorizes criminal penalties against an individual who in any matter within the jurisdiction of any department or agency of the United States knowingly or willfully falsifies, conceals, or covers up by any trick, scheme or device a material fact, or makes any false, fictitious or fraudulent statements or representations, or makes any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry. Individual offenders are subject to fines of up to \$250,000 and imprisonment for up to five years. Offenders that are organizations are subject to fines of up to \$500,000. 18 U.S.C. 3571(d) also authorizes fines of up to twice the gross gain derived by the offender if it is greater than the amount specifically authorized by the sentencing statute.

**Step 3: Begin online application.**

5. Complete the NPI application starting with creating a User ID and password, as indicated on this screen. Click the “Next” button to continue with the NPI application process. Upon completion, you will receive your NPI.

**NPPES**  
National Plan & Provider Enumeration System

Home Help

**NPI Application Form - Select NPI User ID and Password**

\* Indicates Required Field

Please create a User ID and password for future access to NPI:

\* NPI User ID:

Note: Personal information, such as a Social Security Number, should not be used as the User ID. The User ID can contain a maximum of four digits. Please note: The User ID cannot be changed.

\* NPI Password:

\* Retype NPI Password:

Note: Password must be 8-12 characters long, contain at least one letter, one number, no special characters, and not be the same as the User ID.

\* Select Secret Question:

\* Answer:

**Note:**  
1. User IDs cannot be changed. Once you have successfully chosen a User ID and secret question/answer combination and submitted the record, the User ID and secret question/answer combination will remain tied to your record.  
2. Please use the Next button to navigate to the next page in the application.

**WARNING:** Unauthorized access to this system is forbidden and will be prosecuted by law. By accessing this system, both authorized and unauthorized users are subject to monitoring by system personnel. Anyone using this system expressly consents to monitoring and is advised that if such monitoring reveals possible evidence of criminal activity, system personnel may provide the evidence of such monitoring to law enforcement officials.

## To Inform the Texas Department of Aging and Disability Services (DADS) of Your NPI/API

1. Go to [www.dads.state.tx.us/providers/hipaa/forms.html](http://www.dads.state.tx.us/providers/hipaa/forms.html).
2. Click the **Contract NPI/API Association Form (MS Word)** link and complete form.
3. Submit a copy of the NPPES NPI notification and a completed DADS Contract NPI/API Association Form by one of the following methods:
  - FAX: **1-512 438-5522**
  - Postal Mail Service:

Department of Aging and Disability Services  
PO Box 149030, MC W-517  
Austin, TX 78714-9030

NPI is required on claims and assessment submissions using the following methods:

### **Electronic**

- TexMedConnect
- LTC Online Portal

### **Paper**

- 1290 Claim Form

**Note:** *For more information refer to the DADS Information Letter found at:*

[www.dads.state.tx.us/providers/communications/2007/letters/IL2007-110.pdf](http://www.dads.state.tx.us/providers/communications/2007/letters/IL2007-110.pdf)

# The LTC Online Portal

Providers must use the LTC Online Portal to submit MN and LOC Assessments.

## Benefits of Using the LTC Online Portal

- The LTC Online Portal is a web-based application.
- The LTC Online Portal has 24/7 system availability.
- Application edits on the LTC Online Portal verify the validity of data that is entered onto the assessment.
- The LTC Online Portal provides error messages that must be resolved before submission.
- FSI provides a search tool for the status of assessments that have been submitted.
- Current Activity allows providers to view assessment submissions or status changes within the last 14 calendar days.
- Allows providers to submit additional information through the LTC Online Portal.
- TMHP provides LTC Online Portal support by phone at **1-800-626-4117**, Monday through Friday, 7:00 a.m.–7:00 p.m., Central Time.

## LTC Online Portal Security

Third-party vendors are allowed to submit the MN and LOC Assessments directly onto the LTC Online Portal. For questions related to this change in functionality, providers are directed to contact their third-party software vendors.

An administrator account is required for online portal submissions. It is strongly recommended to have multiple administrator accounts, in case one administrator is unavailable.

The administrator account is the primary user account for a provider/contract number. This account has the ability to add/remove permissions (access to LTC Online Portal features) for other user accounts on the same provider/contract number. The provider can establish user accounts for each provider/contract number.

A user account can be created by an administrator. User account permissions and limitations are set by the holder of the administrator account. This allows administrators to set the level of access according to employees' responsibilities.

**Note:** *MDCP nurses obtain LTC Online Portal access directly from HHSC.*

If you already have an account, go to [www.tmhp.com](http://www.tmhp.com). Click the **Access LTC Online Portal** link to login to the LTC Online Portal.

If you do not have an account, follow the steps below under “How to Create an LTC Online Portal Administrator Account.”

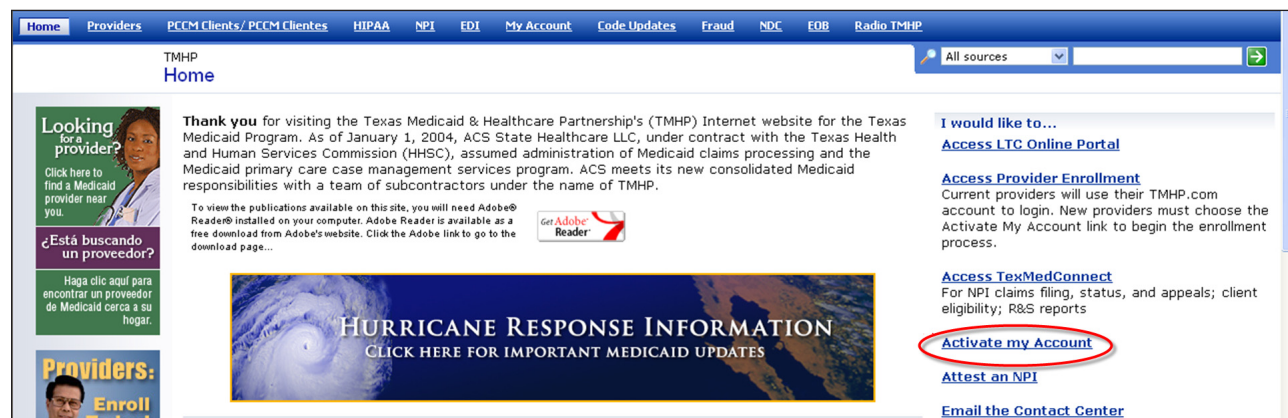
Before you login, you will need to have:

- **Provider number** - assigned by DADS when the provider signs the contract to provide Medicaid services. For HMOs, the provider number is supplied by HHSC.
- **Vendor number** - assigned by DADS to providers who submit MN and LOC Assessments on the LTC Online Portal. For HMOs the vendor number/site ID is supplied by HHSC.
- **Vendor password** - provider must call the Electronic Data Interchange (EDI) Help Desk at **1-888-863-3638** to obtain their vendor password. This password is formally known as the MicroECS password. Please note it may take 3-5 business days to receive the password, which is randomly generated by TMHP.

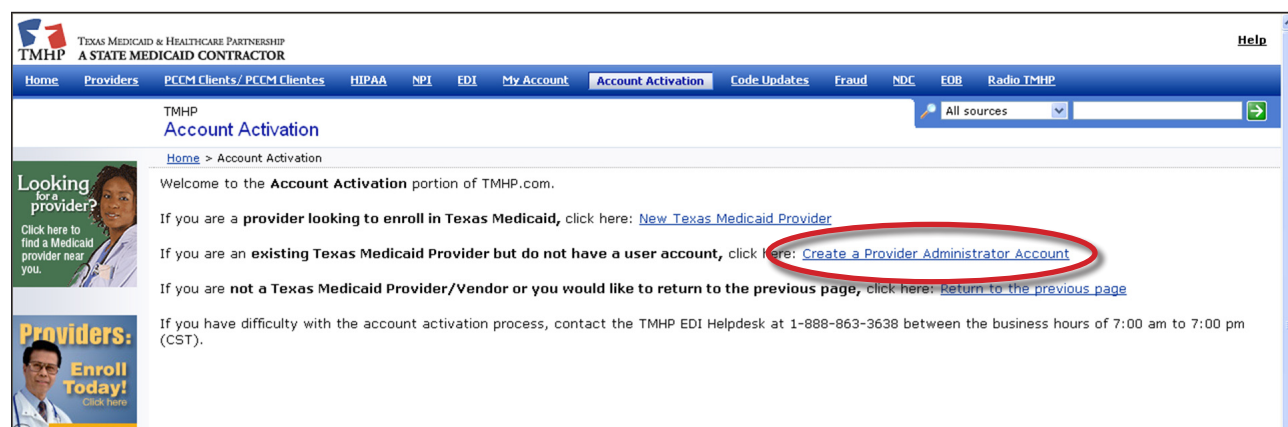
## How to Create an LTC Online Portal Administrator Account

The administrator account is the primary user account. To create an administrator account, follow these steps:

1. Go to [www.tmhp.com](http://www.tmhp.com).
2. Click the **Activate my Account** link.



3. Click the **Create a Provider Administrator Account** link.





4. The following page will appear. Follow the instructions listed at the top of the page and click the **Create a provider/vendor administrator account** link at the bottom of the page.

**update your information.**

**PCCM**  
What is Primary Care Case Management?  
And what does it mean to me?  
¿Que es Primary Care Case Management? Y que significa para mi?

**PROVIDERS**  
**CLIENTS**  
**PARA LOS CLIENTES**

**Current Location**  
▼ Home  
Account Activation

Once validated, the administrator can create and delete additional User Names associated with the Provider Identifier(s). When creating an additional User Name, the administrator selects the Provider Identifier and access privileges associated with the User Name.

When creating or modifying a Provider Administrator account for an existing Provider Identifier, an email notification containing new access settings and administrator information will be sent to each associated User Name. With the addition of a Provider Identifier(s) to a Provider Administrator account, administrators may link an existing User Name and manage access privileges for secure features.

When utilizing contracted services, billing services and clearinghouses are required to obtain access to protected health information through the appropriate administrator of each Provider Identifier.

Validation of the Provider Administrator account includes verifying an internal control number (ICN) for a paid or denied claim found on current Remittance and Status (R&S) reports, dated within the last three calendar weeks. If an ICN is not available, providers may request a Personal Identification Number (PIN) be mailed to their office.

Acute Care providers must enter their 10-digit National Provider Identifier (NPI) and provide the following information:

- ICN or PIN
- NHIC or TMHP electronic data interchange (EDI) submitter ID
- Tax ID (EIN) or Social Security number
- Medical license number

(Depending on the type of NPI, not all fields are required.)

Long Term Care providers must enter their 9-digit provider number and provide the following information:

- ICN or PIN
- NHIC or TMHP EDI submitter ID
- Texas Identification Number (TIN) provided by DADS

(Depending on the type of NPI, not all fields are required.)

Vendors must enter their vendor number and provide the following information:

- ICN or PIN
- Vendor number
- Contract number
- Vendor password

Click here to: [Create a provider/vendor administrator account](#)

For more information about activating and modifying TMHP security features, providers may access the [TMHP.com Security Enhancement Training Guide](#) online.

If difficulty occurs with the account activation process, contact the **TMHP EDI Helpdesk** at 1-888-863-3638, 7:00 a.m. to 7:00 p.m., Central Time.

TMHP encourages providers and vendors to utilize the TMHP website and the current functionality offered.  
Look for additional innovative enhancements and features in the future.

[Terms and Conditions](#) | [Contact Us](#) | [Help](#) | [Site Map](#) | [Employment](#)

5. Provider Type: Choose **NF/Waiver Programs** from the drop-down box.

**Note:** The Provider Types listed are the only two choices in the drop-down box that are applicable for this participant guide.

- Use **NF/Waiver Programs** to submit MN and LOC Assessments. If you already use TexMedConnect, you are still required to create an NF/Waiver Programs account to submit MN and LOC Assessments.
- Use **Long Term Care** to access TexMedConnect (for submitting claims, accessing R&S Reports, performing Medicaid Eligibility and Service Authorization Verifications [MESAVs], etc.).

**TMHP**  
TEXAS MEDICAID & HEALTHCARE PARTNERSHIP  
A STATE MEDICAID CONTRACTOR

**Home** **Providers** **PCCM Clients/ PCCM Clientes** **HIPAA** **NPI** **EDI** **My Account** **Account Activation** **Code Updates** **Fraud** **NDC** **EOB** **Radio TMHP**

**TMHP**  
**Account Activation**

[Home](#) > [Account Activation](#)

**Looking for a provider?**  
Click here to find a Medicaid provider near you.

**Providers: Enroll Today!**  
Click here

**Already enrolled?**

If you are attempting to become a Texas Medicaid Provider and currently do not have a TPI/NPI, select Provider Enrollment from the drop down menu below.

If you are an existing Texas Medicaid Provider and you wish to create a Provider Administrator account, use the following guidelines and choose your selection from the drop down menu below:

- To register as an acute care provider, choose Acute Care.
- To register as a hospice provider and have the ability to view R&S reports and submit 3071s and 3074s, choose Long Term Care.
- All other providers (e.g., nursing facilities) wanting to submit 3618s, 3619s, 3652s, MDS, MDS Quarterly, MN/LOC, and PASARR Screenings, choose NF/Waiver Programs.

**Provider Type:** --Select--

- Select--
- Acute Care
- Long Term Care
- NF/Waiver Programs
- Provider Enrollment

6. Enter your provider number, vendor number, and vendor password.



- Click the “Next” button.

- Check the “General Terms and Conditions” box at the bottom of the screen to indicate agreement.
- Click the **Create Provider Administrator** link to create your User name and password.

**Note:** *The User name and password are used for future logins to your account. Make a copy for your records.*

## My Account

**My Account** is used to perform various maintenance activities for your account, such as setting up user accounts, changing passwords, and other administrative tasks.

To access **My Account**:

- Go to [www.tmhp.com](http://www.tmhp.com).
- Click the **My Account** link in the blue navigational bar.

The “Help” section on this screen has a provider training guide to assist in setting up an account.

## Login to the LTC Online Portal

Now that your User name has been created:

1. Go to [www.tmhp.com](http://www.tmhp.com).
2. Click the **Access LTC Online Portal** link.



3. Enter your User name and password.
4. Click the “OK” button. After login, FSI will display by default:

A screenshot of the 'Form Status Inquiry' page on the TMHP website. The top navigation bar includes links like 'Home', 'Submit Form', 'Form Status Inquiry' (circled in red), 'Current Activity', 'My Drafts', 'Printable Forms', and 'Help'. The page title is 'Form Status Inquiry'. Below the title, there's a 'Form Select' section with a 'Type of Form' dropdown menu. The 'Form Status Inquiry' section contains input fields for 'DLN', 'Medicaid Number', 'Last Name', 'First Name', 'SSN', 'Form Status' (dropdown), 'From Date' (calendar), and 'To Date' (calendar). A 'Search' button is at the bottom right.

# Portal Basics

## Blue Navigational Bar Links

All portal features are based on your security level and can be found in the blue navigational bar located at the top of the portal screen.

Options found in the blue navigational bar may include: Home, Submit Form, Form Status Inquiry, Current Activity, My Drafts, Printable Forms, and Help.



## Home

When the blue navigational bar above is displayed, the **Home** link at the far left will take you to “My Account.” If you are already at the “My Account” page, the **Home** link will take you back to the [www.tmhp.com](http://www.tmhp.com) home page.



## Submit Form

This feature allows providers to submit **Waiver: Medical Necessity and Level of Care Assessments**.

**TMHP** TEXAS MEDICAID & HEALTHCARE PARTNERSHIP  
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Home Submit Form Form Status Inquiry Current Activity My Drafts Printable Forms Help

### Submit Form

**Form Select**

Type of Form Waiver: Medical Necessity and Level of Care Assessment

**Recipient**

To prepopulate recipient information please provide one of the following combinations of information.  
 Medicaid/CSHCN ID  
 or Social Security Number AND Last Name  
 or Social Security Number AND Date of Birth  
 or Date of Birth AND Last Name AND First Name

Medicaid Number

SSN

Date of Birth

First Name

Last Name

## MEDICAL NECESSITY AND LEVEL OF CARE ASSESSMENT

Current Status: Resident Name: DLN:0 RUG:

## Form Actions:




Section AA.	Section A.	Section B.	Section C.	Section D.
Section E.	Section G.	Section H.	Section I.	Section J.
Section K.	Section M.	Section N.	Section O.	Section P.
Section Q.	Section R.	Section LTCMI.	Section U.	

SECTION AA: IDENTIFICATION INFORMATION	
1. Individual Name	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> a. (First) b. (Middle Initial) c. (Last) d. (Suffix Jr/Sr)
2. Gender	<input type="text"/>
3. Birth date	<input type="text"/>
4. Race/Ethnicity	<input type="text"/>
5. Social Security and Medicare Numbers. [Either Social Security Number or Medicare Number is required.]	a. Social Security Number <input type="text"/> b. Medicare number (or comparable railroad insurance number) <input type="text"/>
7. Medicaid No. ['+' if pending, 'N' if not a Medicaid Recipient]	<input type="text"/>
8. Reasons for Assessment	[Note - Other codes do not apply to this form] a. Primary reason for assessment <input type="text"/>

History	<input type="button" value="Submit Form"/>
---------	--

**Note:** The steps to submit MN and LOC Assessments are covered in the “Medical Necessity and Level of Care Assessment” section.

## Form Status Inquiry

FSI is a query tool for monitoring the status of assessments that have been submitted.

This allows providers to retrieve assessments in order to:

- Access assessments to research and review statuses.
- Provide additional information to an assessment.
- Retrieve assessments to perform a correction or inactivation. (See “Corrections” and “Inactivations” sections within this participant guide.)

The screenshot shows the 'Form Status Inquiry' page of the Texas Medicaid & Healthcare Partnership (TMHP) A State Medicaid Contractor. The page has a blue header with navigation links: Home, Submit Form, **Form Status Inquiry**, Current Activity, My Drafts, Printable Forms, and Help. Below the header, there is a 'Form Select' section with a 'Type of Form' dropdown menu. The main section is titled 'Form Status Inquiry' and contains several input fields: DLN, Last Name, SSN, From Date (set to 3/2/2009), Medicaid Number, First Name, Form Status (dropdown), and To Date (set to 4/1/2009). A 'Search' button is located at the bottom right of the form.

1. Click the **Form Status Inquiry** link in the blue navigational bar.
2. Type of Form: Choose **Waiver: Medical Necessity and Level of Care Assessment** from the drop-down box.

- Enter data for all required fields as indicated by the red dots. Narrow results by entering specific criteria in the additional fields: “DLN,” “Last Name,” “First Name,” “SSN,” “Medicaid Number,” “Form Status,” “From Date” and “To Date.”

**Note:** The “From Date” and “To Date” fields are searched against the “TMHP Received Date” (e.g., the date the assessment was successfully submitted).

- Click the “Search” button.
- Click the **View Detail** link of the requested assessment.

50 record(s) returned.  
Not all records returned. This search is limited to return 50 records. Please narrow your search.

	DLN	TMHP Received Date	SSN	Medicaid #	Medicare #	First Name	Last Name	Status	RUG	RN Signature Date	Purpose Code	Contract Number	Vendor Number	Reason For Assessment
<a href="#">View Detail</a>		3/21/2009						Processed/Complete	PD1	3/6/2009				2. Annual assessment
<a href="#">View Detail</a>		3/21/2009						Medicaid ID Pending	IA1	3/10/2009				2. Annual assessment
<a href="#">View Detail</a>		3/21/2009						Medicaid ID Pending	PB1	3/16/2009				2. Annual assessment
<a href="#">View Detail</a>		3/23/2009						Processed/Complete	SSB	3/11/2009				2. Annual assessment
<a href="#">View Detail</a>		3/23/2009						Processed/Complete	PA1	3/16/2009				2. Annual assessment

Descriptions of the column headings seen above are:

- View Detail:** The hyperlink used to open the assessment.
- DLN:** The unique document locator number (DLN) assigned to each successfully submitted assessment.
- TMHP Received Date:** The actual date the assessment was successfully submitted on the LTC Online Portal.
- SSN (AA5a), Medicaid # (AA7), Medicare # (AA5b), First Name and Last Name (AA1):** Information used to identify the individual associated with assessment.
- Status:** The status of the assessment at the time of search.
- RUG:** The assigned Resource Utilization Group (RUG) value.
- RN Signature Date:** Date the assessment was completed as identified in field R2b.
- Purpose Code:**
  - Purpose Code 1: The Utilization Review Assessment.
- Contract Number:** The nine-digit provider number.
- Vendor Number:** The four-digit site identification number.
- Reason for Assessment (AA8a):**
  - 01: Initial Assessment
  - 02: Annual Assessment
  - 03: Significant Change in Status Assessment

## Current Activity

Providers have the ability to view assessment submissions or status changes within the last 14 calendar days.

- Click the **Current Activity** link in the blue navigational bar.
- Click the appropriate vendor number (if applicable).

**TMHP** TEXAS MEDICAID & HEALTHCARE PARTNERSHIP  
A STATE MEDICAID CONTRACTOR

Home Submit Form Form Status Inquiry **Current Activity** My Drafts Printable Forms Help

**Current Activity**

The user name is associated with the following Vendor/Contract numbers. Select the Vendor/Contract number to configure a administrator account.

**Vendor Numbers**

for Contract Number

3. The results will display a summary of all assessment submissions or status changes within the last 14 calendar days.

Waiver	Received	SSN	Medicaid	Medicare	Name	Status
0000000000	9/11/2008 1:44:01 PM	0000000000	0000000000	0000000000	0000000000	Processed/Complete
0000000000	10/13/2008 8:56:43 AM	0000000000	0000000000	0000000000	0000000000	Med ID Check Inactive
0000000000	10/21/2008 2:28:25 PM	0000000000	0000000000	0000000000	0000000000	Denied
0000000000	10/27/2008 2:04:04 PM	0000000000	0000000000	0000000000	0000000000	Submitted to manual workflow
0000000000	11/19/2008 3:04:18 PM	0000000000	0000000000	0000000000	0000000000	Denied
0000000000	3/3/2009 3:40:41 PM	0000000000	0000000000	0000000000	0000000000	Denied
0000000000	3/4/2009 4:27:52 PM	0000000000	0000000000	0000000000	0000000000	Denied
0000000000	3/13/2009 3:35:40 PM	0000000000	0000000000	0000000000	0000000000	Submitted to manual workflow
0000000000	3/16/2009 10:33:19 AM	0000000000	0000000000	0000000000	0000000000	Denied
0000000000	3/19/2009 3:13:19 PM	0000000000	0000000000	0000000000	0000000000	Pending Denial (need more information)
0000000000	3/20/2009 2:20:40 PM	0000000000	0000000000	0000000000	0000000000	Processed/Complete
0000000000	3/20/2009 4:49:50 PM	0000000000	0000000000	0000000000	0000000000	Pending Denial (need more information)
0000000000	3/21/2009 9:51:36 AM	0000000000	0000000000	0000000000	0000000000	Processed/Complete
0000000000	3/24/2009 11:52:26 AM	0000000000	0000000000	0000000000	0000000000	Denied

Descriptions of the column headings seen above:

- **Waiver:** The unique DLN assigned to each successfully submitted assessment.
- **Received:** The actual date the assessment was successfully submitted on the LTC Online Portal.
- **SSN (AA5a), Medicaid (AA7), Medicare (AA5b), First Name and Last Name (AA1):** Information used to identify the individual associated with assessment.
- **Status:** The status of the assessment.

4. Click the **document locator number** (DLN) link of the requested assessment to view in detail.

Providers are able to sort the Current Activity in a variety of ways. By clicking on the heading of a column, the provider can choose to sort results by DLN, Received Date, SSN, Medicaid Number, Medicare Number, Name, or Status. When the provider clicks on a column heading the first time, it is sorted in ascending order. By clicking on the column heading a second time, the sort will change to descending order.

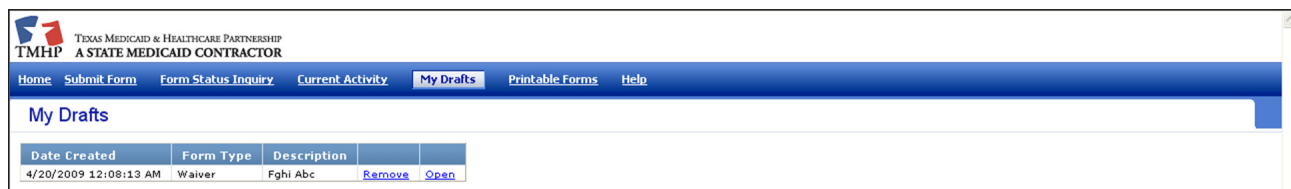
## My Drafts

This feature allows the user to access all drafts previously saved under the specific User name that was used to create the original draft.

**Note:** *Only the user who created the original draft will be able to access the draft. Other users, including the administrator, will not have access to drafts saved under another User name.*

To access a saved draft:

1. Click the **My Drafts** link in the blue navigational bar.



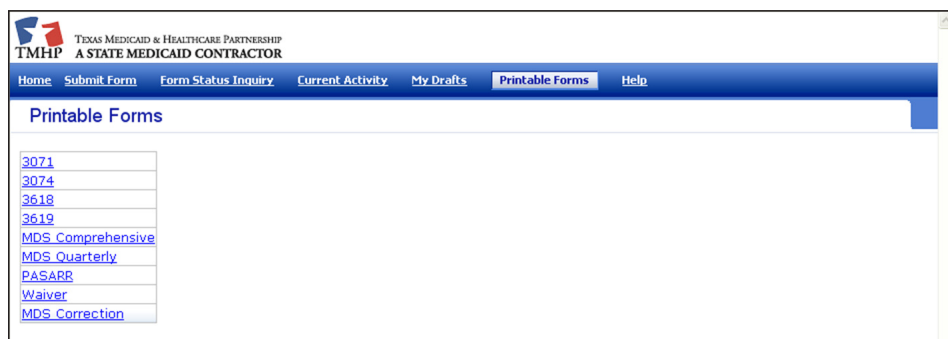
2. From here:
  - a. Click the **Open** link to open the draft assessment to edit and submit.
  - or**
  - b. Click the **Remove** link to permanently delete the draft assessment.

**Note:** *Once a draft has been removed, it cannot be retrieved.*

## Printable Forms

This feature allows the provider to view and/or print blank assessments:

1. Click the **Printable Forms** link in the blue navigational bar.



- Click the **Waiver** link. Adobe Reader® will open in a new window and will display the blank assessment in portable document format (PDF).

Please fill out the following form. You cannot save data typed into this form. Please print your completed form if you would like a copy for your records.

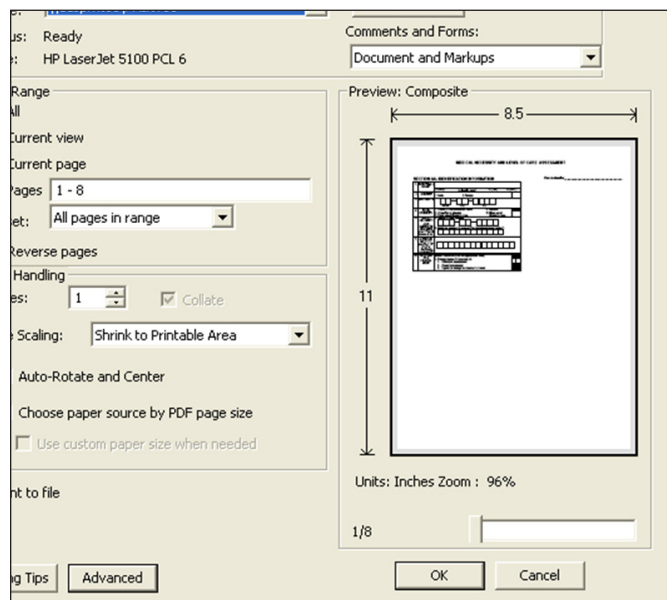
**MEDICAL NECESSITY AND LEVEL OF CARE ASSESSMENT**

Section AA. IDENTIFICATION INFORMATION

Numeric Identifier \_\_\_\_\_

1. INDIVIDUAL NAME*	a. (First) b. (Middle Initial) c. (Last) d. (Jr/Sr)			
2. GENDER*	1. Male 2. Female			
3. BIRTHDATE	Month	Day	Year	
4. RACE/ETHNICITY	1. American Indian/Alaskan Native 2. Asian/Pacific Islander 3. Black, not of Hispanic origin 4. Hispanic 5. White, not of Hispanic origin			

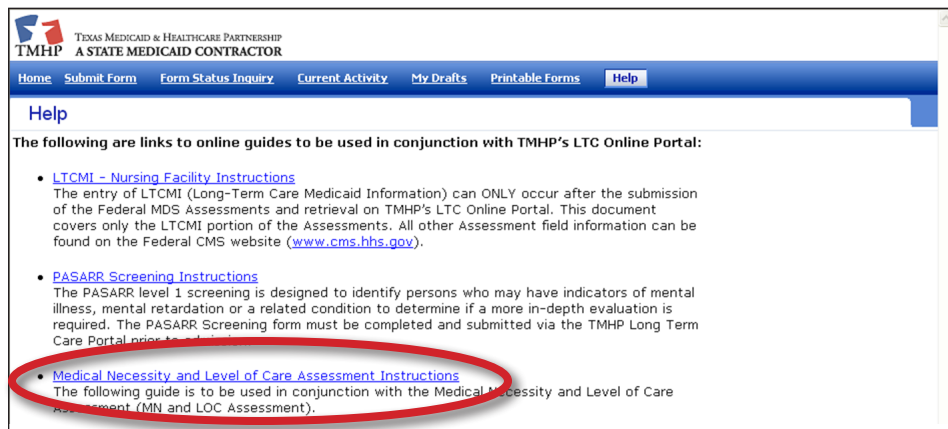
- Click the “Print” Icon.
- To print the entire document:
    - Printer: Choose the appropriate printer name from drop-down box.
    - Print Range: Click the “All” circle.
    - Click the “OK” button.
  - To print certain pages, instead of the entire document:
    - Printer: Choose the appropriate printer name from drop-down box.
    - Print Range: Click the “Pages” circle.
    - Enter the pages to print. (example: 1-5 will print all pages 1 through 5; 1,3,7 will print only pages 1, 3 and 7.)
    - Click the “OK” button.





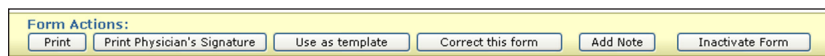
## Help

The **Help** link at the far right in the blue navigational bar will display a “Help” page consisting of links to online guides that will assist with questions you may have about the TMHP LTC Online Portal. Registered nurses (RNs) can get assistance with completing the MN and LOC Assessment by clicking the **Medical Necessity and Level of Care Assessment Instructions** link.



## Yellow Form Actions Bar

Options found in the yellow Form Actions bar may include: Print, Print Physician's Signature, Use as template, Correct this form, Add Note, and Inactivate Form. Options will vary depending on your security as well as the assessment status. The yellow Form Actions bar is available when an individual assessment is being viewed in detail.



## Print

This feature allows the provider to print completed MN and LOC Assessments. Click the “Print” button to print completed assessments.

**Note:** To only print specific sections of the assessment, click the Pages circle and enter the page range for the desired pages only. When printing the LTCMI section of the MN and LOC Assessment, the individual's name will appear on the top left corner of each page. The name will be auto populated based on the information entered in field AA1.

## Print Physician's Signature

This feature allows a provider to generate and print a Physician's Signature page at any time. However, it is only required when completing an Initial Assessment (01). Field S7e (Physician's Signature on File) may be used to indicate that the physician's signature is already on file.

To print a Physician's Signature page, click the “Print Physician's Signature” button located in the yellow Form Actions bar.



## Use as template

This feature allows a provider to complete a new assessment by using the information in a previously completed assessment as a template. Various fields will auto populate; be sure to check for accuracy.

Once you have found the assessment using FSI or Current Activity:

1. Click the “Use as template” button. The data in this assessment will be used to create a new assessment.

**Note:** Modify assessment data to reflect the current status of the individual. Also, adjust the Reason for Assessment if necessary (i.e., if you chose to use an Initial assessment as a template for the Annual assessment, don't forget to change the Reason for Assessment from Initial to Annual).

2. Enter data into remaining fields that are not auto populated.

**Note:** Fields not auto populated are: Assessment Reference Date (ARD), Date Assessment was Completed (R2b) and Admission to Medicaid Date (S1b).

3. Click the “Print” button located in the yellow Form Actions bar to print the assessment in progress. (If you want a hard copy for your records).
4. From here:
  - a. Click the “Submit Form” button located at the bottom right of the screen, if ready to submit for processing.

**or**

  - b. Click the “Save as Draft” button located in the yellow Form Actions bar to save an assessment as a draft until ready to submit.

## Correct this form

This feature allows providers to perform corrections to the MN and LOC Assessment within 14 calendar days of the original submission (e.g., TMHP received date). However, corrections are not allowed if an assessment is set to status “Form Inactivated” or “Invalid/Complete”.

**Note:** The steps to correct an assessment are covered in the “Corrections” section.

## Add Note

The “Add Note” feature located in the yellow Form Actions bar may be used to add additional MN information not captured upon original submission or if the assessment is set to status “Pending Denial (need more information).” This information will be added to the History trail of the assessment, not to the assessment itself (e.g., not added to S8. Comments). This information is not used in system processing.

If an assessment is set to status “Pending Denial (need more information)” and a note is added, the assessment is set to status “Pending Review,” and the additional information will be reviewed by a TMHP nurse.

To add a note to a submitted assessment:

1. Locate the assessment using the FSI or Current Activity.
2. Click the “Add Note” button, a text box will open.

3. Enter additional information (up to 500 characters) to the text box.

4. Click the “Save” button to save your note or “Cancel” button to erase your note, located under the text box.

History	
Form Submitted	3/28/2009 10:16:57 AM
Pending Review	3/28/2009 10:16:58 AM
3/28/2009 10:16:58 AM	TMHP : The Form has failed Auto MN Approval
Pending Denial (need more information)	3/30/2009 8:36:08 AM
4/20/2009 12:18:11 AM	provider_ext52 : Test test test
Pending Review	4/20/2009 12:18:17 AM
4/20/2009 12:18:17 AM	TMHP : Form notes have been updated. Form has been re-submitted for nurse review.

**Note:** If unsure why an assessment is set to status “Pending Denial (need more information)” please call the TMHP Help Desk (1-800-626-4117, Option 2) to speak with a nurse. If “Add Note” is chosen to any assessment set to status “Pending Denial (need more information)” the assessment will be reviewed again for medical necessity. If the nurse is unable to ap-

*prove the assessment with the additional information provided, the assessment will be sent to the TMHP Medical Director for review and determination of medical necessity.*

## Inactivate Form

This feature allows providers to inactivate a MN and LOC Assessment. Once inactivated, the assessment will not be available for further processing, but it may be used as template. Inactivations are not allowed if an assessment is set to status “Corrected.”

**MEDICAL NECESSITY AND LEVEL OF CARE ASSESSMENT**

Current Status: Processed/Complete Resident Name: DLN RUG: PE1

**Form Actions:**

Print Print Physician's Signature Use as template Add Note **Inactivate Form**

Section AA.	Section A.	Section B.	Section C.	Section D.
Section E.	Section G.	Section H.	Section I.	Section J.
Section K.	Section M.	Section N.	Section O.	Section P.
Section Q.	Section R.	Section LTCMI.	Section U.	

**Note:** The steps to inactivate an assessment will be covered in the “Inactivations” section.

## Other Basic Information

### Required Fields

Within the portal, red dots indicate required fields. Fields without the red dot are optional.

**TMHP** TEXAS MEDICARE & MEDICAID PARTNERSHIP

Home Sub

**Form Select**

Type of Form ●

**Form Status Inquiry**

DLN  Medicaid Number

Last Name  First Name

SSN  -  -  Form Status

From Date ● 3/2/2009  To Date ● 4/1/2009

Search

## History

An assessment's history can be found by scrolling down on an open assessment. This History trail shows the different statuses the assessment has held. The most recent status will appear at the bottom.

History	
Form Submitted	3/25/2009 2:52:36 PM
Pending Review	3/25/2009 2:52:37 PM
3/25/2009 2:52:37 PM	TMHP : The Form has failed Auto MN Approval
Approved	3/26/2009 9:09:39 AM
Medicaid ID Pending	3/26/2009 9:09:47 AM
3/26/2009 9:09:47 AM	TMHP : Medicaid ID request submitted
ID Confirmed	3/26/2009 9:09:49 AM
3/26/2009 9:09:49 AM	TMHP : Medicaid ID [REDACTED] confirmed for this client
SAS Request Pending	3/26/2009 9:09:50 AM
3/26/2009 9:09:50 AM	TMHP : The request is being processed by DADS. Please allow 2-4 business days for the next status change.
Processed/Complete	3/27/2009 5:06:03 AM
3/27/2009 5:06:03 AM	TMHP : SAS Change Request successful.

## UnLock Form

Upon opening, the assessment becomes automatically locked by the viewer and will remain locked for 20 minutes of no activity or until the viewer clicks the “UnLock Form” button. The “UnLock Form” button will unlock the assessment so that a different user can make changes. If an assessment is locked, others will not be able to make changes or add additional information. You may be asked to unlock an assessment if you are seeking assistance from TMHP or DADS.

To unlock an assessment, click the “UnLock Form” button located at the top right corner of the screen.

## Error Messages

If required information is missing or information is invalid, an error message(s) will display, and you will not be able to continue to the next step until the error is resolved. You may need to scroll up to find the section containing the error, or you may click the error message hyperlink to be directed automatically to the field(s) containing the error.

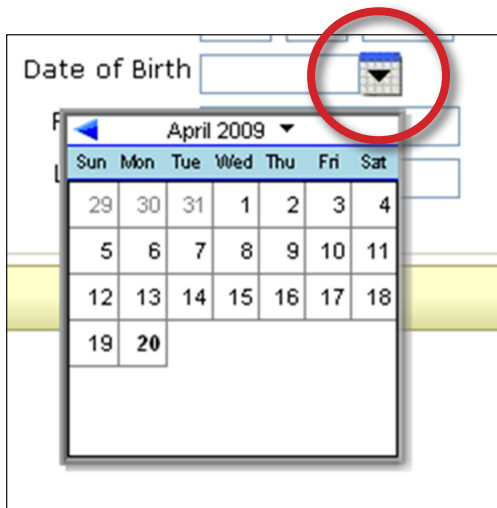
**Please fix these errors**

- [Type of Form is required](#)

**The page will not submit until these are corrected.**

## Entering Dates

To enter dates, you have the option to click on the calendar icon next to any of the date fields to activate the dynamic calendar. Choose the date desired. Or, you may manually enter in the date using the mm/dd/yyyy format.



## Timeout

The assessment will automatically timeout after 20 minutes of no activity. To prevent this timeout from occurring, complete and submit the assessment within 20 minutes or click on a different tab (e.g., Section A) to reset the timer, then return to the previous tab.

# Medical Necessity and Level of Care Assessment

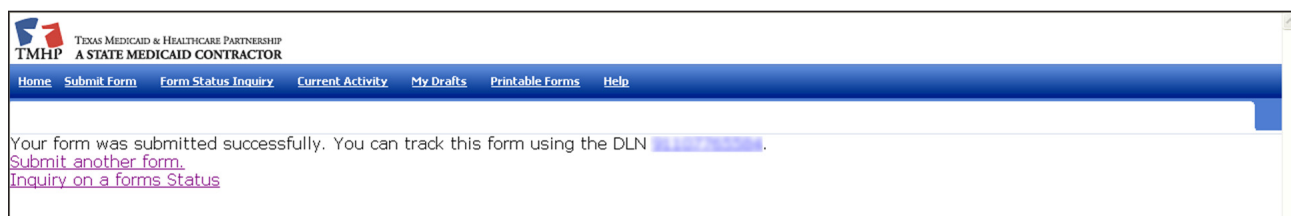
MN and LOC Assessments are submitted to determine medical necessity for individuals in the community.

There are three reasons to submit an MN and LOC Assessment:

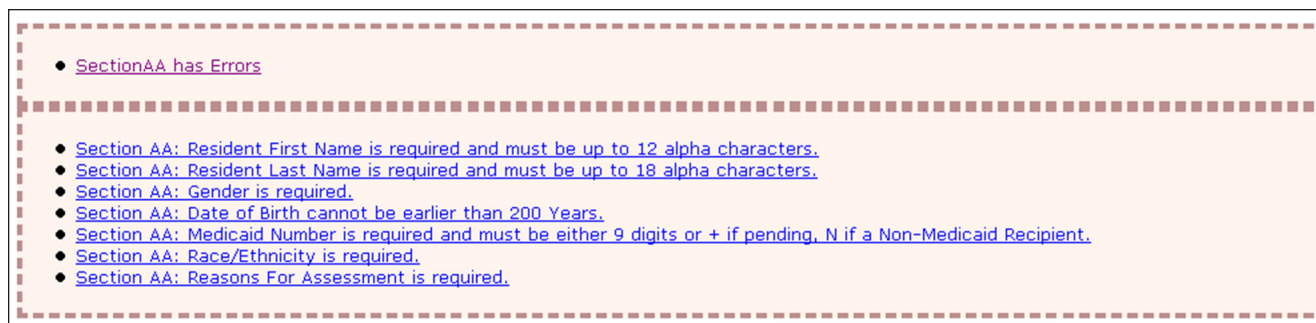
- **AA8a = 01.** Initial Assessment
- **AA8a = 02.** Annual Assessment
- **AA8a = 03.** Significant Change in Status Assessment (SCSA), submitted when authorized by the case manager due to changes in the medical condition of the individual.

**Note:** HMO's complete the SCSA but do not submit on the portal. Print and keep in individual's records.

All assessments must be submitted through the LTC Online Portal. If the assessment is submitted successfully, a DLN will be assigned and the following message will be displayed.



If an assessment is not successfully submitted, an error message will appear at the top of the screen. The provider must resolve the error(s) to ensure the assessment will be submitted successfully. The error message will prompt the provider as to how to resolve the error or save to draft for research and correction at a later date. If the provider is unable to resolve the error, they may contact TMHP and choose option one for assistance.



**Note:** The TMHP LTC Online Portal will not accept an MN and LOC Assessment with a calculated BC1 RUG. Details of how to resolve a BC1 RUG are located in the "How to Correct BC1 RUG" section of this Participant Guide.

## How to Submit a Medical Necessity and Level of Care Assessment

1. Login to the LTC Online Portal.
2. Click the **Submit Form** link located in the blue navigational bar.
3. Type of Form: Choose **Waiver: Medical Necessity and Level of Care Assessment** from the drop-down box.

4. To auto populate an individual's information in the MN and LOC Assessment, enter one of the following combinations of information:
  - Medicaid/Children with Special Healthcare Needs (CSHCN) ID
  - or**
  - Social Security Number AND Last Name
  - or**
  - Social Security Number AND Date of Birth
  - or**
  - Date of Birth AND Last Name AND First Name

**Note:** All demographic information (except gender) is auto populated when one of the aforementioned data items is entered. Refer to the "MN and LOC" section AA.

5. Click the "Enter Form" Button.



6. Click the tabs (i.e., “Section AA,” “Section A,” “Section B,” etc) and enter the assessment information.

a. Click the “Submit Form” button to submit the MN and LOC Assessment.

**or**

b. For initial assessments, click the “Print Physician Signature” button. Then click the “Save as Draft” button to save an MN and LOC Assessment to be recalled later.

**MEDICAL NECESSITY AND LEVEL OF CARE ASSESSMENT**

Current Status: Resident Name: DLN:0 RUG:

Form Actions:

Print Print Physician's Signature Save as Draft

Section AA.	Section A.	Section B.	Section C.	Section D.
Section E.	Section G.	Section H.	Section I.	Section J.
Section K.	Section M.	Section N.	Section O.	Section P.
Section Q.	Section R.	Section LTCMI.	Section U.	

**SECTION AA: IDENTIFICATION INFORMATION**

1. Individual Name

a. (First) b. (Middle Initial) c. (Last) d. (Suffix Jr/Sr)

2. Gender

3. Birth date

4. Race/Ethnicity

5. Social Security and Medicare Numbers. [Either Social Security Number or Medicare number is required.]

a. Social Security Number

b. Medicare number (or comparable railroad insurance number)

7. Medicaid No. ['+' if pending, 'N' if not a Medicaid Recipient]

8. Reasons for Assessment [Note - Other codes do not apply to this form]

a. Primary reason for assessment

History

Submit Form

7. Once the physician’s signature has been obtained, click the **My Drafts** link in the blue navigational bar.

8. Click the **Open** link.

9. Click the “LTCMI” tab. Check the S7E box (Physician’s Signature on File).

10. Click the “Submit Form” button.

## Overview of the MN and LOC Assessment

Form Actions:				
<a href="#">Print</a>	<a href="#">Print Physician's Signature</a>	<a href="#">Save as Draft</a>		
Section AA.	Section A.	Section B.	Section C.	Section D.
Section E.	Section G.	Section H.	Section I.	Section J.
Section K.	Section M.	Section N.	Section O.	Section P.
Section Q.		Section R.	Section LTCMI.	Section U.

The MN and LOC Assessment consists of 19 sections:

- Section AA: Identification Information
- Section A: Identification and Background Information
- Section B: Cognitive Patterns
- Section C: Communication/Hearing Patterns
- Section D: Vision Patterns
- Section E: Mood and Behavior Patterns
- Section G: Physical Functioning and Structural Problems
- Section H: Continence in the Last 30 Days
- Section I: Diseases/Diagnoses
- Section J: Health Conditions
- Section K: Oral/Nutritional Status
- Section M: Skin Conditions
- Section N: Activity Pursuit Patterns
- Section O: Medications
- Section P: Special Treatments and Procedures
- Section Q: Discharge Potential and Overall Status
- Section R: Signature/Date Completed
- Section U: Medications
- Section LTCMI

Detailed explanations of the MN and LOC Assessment sections can be found at the following locations:

- Go to [www.tmhp.com/LTC\\_Programs/default.aspx](http://www.tmhp.com/LTC_Programs/default.aspx) and click the **Medical Necessity and Level of Care Instructions** link found under the Community Waivers Programs heading; or
- Click the **Help** link in the blue navigational bar and click the **Medical Necessity and Level of Care Instructions** link.

Blank MN and LOC Assessments can be found at the following locations:

- Go to [www.tmhp.com/LTC\\_Programs/default.aspx](http://www.tmhp.com/LTC_Programs/default.aspx) and click the **Medical Necessity and Level of Care Assessment** link found under the Community Waivers Programs heading; or
- Click the **Printable Forms** link in the blue navigational bar and click the **Waiver** link.

**Note:** For reference only, a blank MN and LOC Assessment is located in the appendix at the back of this Participant Guide.

## Long Term Care Medicaid Information (LTCMI)

MEDICAL NECESSITY AND LEVEL OF CARE ASSESSMENT				
Current Status: Resident Name: DLN:0 RUG:				
Form Actions:				
<input type="button" value="Print"/> <input type="button" value="Print Physician's Signature"/> <input type="button" value="Save as Draft"/>				
Section AA.	Section A.	Section B.	Section C.	Section D.
Section E.	Section G.	Section H.	Section I.	Section J.
Section K.	Section M.	Section N.	Section O.	Section P.
Section Q.		Section R.	Section LTCMI.	Section U.
LTC MEDICAID INFORMATION				
S1. Medicaid Information				
S1a.	Medicaid Client Indicator <input type="text"/>			
S1b.	Admission to Medicaid Date <input type="text"/>			
S1c.	Admitted From <input type="text"/>			
S1d.	Individual Address <input type="text"/>			
S1e.	City <input type="text"/>			
S1f.	State <input type="text"/>			
S1g.	ZIP Code <input type="text"/>			
S2. Claims Processing Information				
S2a.	DADS Vendor/Site ID Number 0000			
S2b.	Contract/Provider Number 000000000			
S2c.	Service Group <input type="text"/>			
S2d.	NPI Number D000000000			
S2e.	Region <input type="text"/>			
S2f.	Purpose Code <input type="text"/>			
S3. Primary Diagnosis				
S3a.	<div style="display: flex; border-bottom: 1px solid black;"> <span style="width: 20%;">Primary Diagnosis ICD-9</span> <span style="width: 80%;">Description</span> </div> <div style="display: flex; border-bottom: 1px solid black;"> <input style="width: 20%;" type="text"/> <input style="width: 80%;" type="text"/> </div>			
S5. Licenses				
Provider Certification: I certify to completeness of this information				
S5a.	DADS RN Last Name <input type="text"/>			
S5b.	DADS RN License# <input type="text"/>			
S5b1	DADS RN License State <input type="text"/>			
S5c.	HHA RN Last Name <input type="text"/>			
S5d.	HHA RN License# <input type="text"/>			
S5d1	HHA RN License State <input type="text"/>			
S5e.	DADS UR RN Last Name <input type="text"/>			
S5f.	DADS UR RN License# <input type="text"/>			
S5f1	DADS UR RN License State <input type="text"/>			
S5g1.	Is DADS UR RN Signature on Form? <input type="checkbox"/>			
S5g.	DADS UR RN Signature Date <input type="text"/>			
S5h.	PACE RN Last Name <input type="text"/>			
S5i.	PACE License# <input type="text"/>			
S5i1	PACE License State <input type="text"/>			
S5j.	HMO RN Last Name <input type="text"/>			
S5k.	HMO RN License# <input type="text"/>			
S5k1	HMO RN License State <input type="text"/>			
S6. Therapeutic Interventions				
S6a.	Tracheostomy Care <input type="text"/>			
S6b.	Ventilator/Respirator <input type="text"/>			
S7. Physician's Evaluation & Recommendation				
S7a.	I certify that this individual requires nursing facility services or alternative community based services under supervision of an MD/DO. <input type="text"/>			
S7b.	MD/DO Last Name <input type="text"/>			
Either MD/DO License# or MD/DO Military Spec Code is required.				
S7c.	MD/DO License# <input type="text"/>			
S7c1	MD/DO License State <input type="text"/>			
S7d.	MD/DO Military Spec Code# <input type="text"/>			
S7e.	Physician's Signature on File. <input type="checkbox"/>			
S8. Comments				
<div style="border: 1px solid #ccc; padding: 5px;"></div>				

- **S1. Medicaid Information.**

- S1a. Medicaid Client Indicator.
  - Choose “1” if Medicaid Client.
- S1b. Admission to Medicaid Date (date of the assessment or the date of the last face to face assessment). Refer to your MN and LOC item by item guide for additional information.
- S1c. Admitted From:
  1. Home.
  2. Hospital.
  3. Nursing Facility.
  4. State school/Facility.
  5. Other.
  6. Cannot Determine.
- S1d. Individual Address (Enter street address of individual or Legally Authorized Representative).
- S1e. City.
- S1f. State.
- S1g. Zip Code.

This address is used to send client letters (i.e., denial letters).

- **S2. Claims Processing Information.**

- S2a. DADS Vendor/Site ID Number.
- S2b. Contract/Provider Number.
- S2c. Service Group.
- S2d. NPI Number (required field).

This is where API would be entered if using an API number. API is “D,” two zeros, then contract number (i.e., MDCP nurses would use an API).

- S2e. Region.
- S2f. Purpose Code.
- S2f Purpose Code 1: Is used for Utilization Review (UR) only. This field is auto populated and unavailable for data entry.

**Note:** *DADS RN performs the MDCP assessment & DADS UR RN performs the quality assessments (Purpose Code 1). This UR assessment will override the assessment by the provider.*

- **S3. Primary Diagnosis.**

- S3a. Primary Diagnosis International Classification of Diseases Ninth Revision (ICD-9).

Enter a valid ICD-9 code for the individual’s primary diagnosis. Use your best clinical judgment.
- S3b. Primary Diagnosis ICD-9 description.

To populate the ICD-9 description, click the magnifying glass icon.

- **S4. For DADS use only.**

- **S5. Licenses.**

- S5a. DADS RN Last Name.
- S5b. DADS RN License #.
- License number entered is validated against Texas State University RUG training database, and the Board of Nursing (BON) database.
- S5b1. DADS RN License State.

**Note:** *S5a-S5b1 are required for Service Group (SG) 18 MDCP.*

- S5c. HHA (Home Health Agency) RN Last Name.
- S5d. HHA RN License #.
- License number entered is validated against Texas State University RUG training database, and the Board of Nursing (BON) database.
- S5d1. HHA RN License State.

**Note:** *S5c-S5d1 are required for SG 3 CBA/ICM and SG 17 CWP.*

- S5e. DADS UR (Utilization Review) RN Last Name.
- S5f. DADS UR RN License #.
- License number entered is validated against Texas State University RUG training database, and the Board of Nursing (BON) database.
- S5f1. DADS UR RN License State.
- S5g1. Is DADS UR RN Signature on Assessment.
- S5g. DADS UR RN Signature Date.

**Note:** *S5e-g are required for utilization reviews.*

- S5h. PACE RN Last Name.
- S5i. PACE License #.
- License number entered is validated against Texas State University RUG training database, and the Board of Nursing (BON) database.
- S5i1. PACE License State.

**Note:** *S5h-S5i1 are required for PACE SG 11.*

- S5j. HMO (Health Maintenance Organization) RN Last Name.
- S5k. HMO RN License #.
- License number entered is validated against Texas State University RUG training database, and the Board of Nursing (BON) database.
- S5k1. HMO RN License State.

\*STAR+PLUS HMO providers will enter HMO RN last name and license number in lieu of DADS RN information.

**Note:** *S5j-S5k1 are required for STAR+PLUS SG 19.*

- **S6. Therapeutic Interventions.**

- S6a. Tracheostomy Care.

Required. A non-zero reply is required if assessment field P1aj, Tracheostomy care, is checked.

- S6b. Ventilator/Respirator (Do not include BiPAP or CPAP time).

- **S7. Physician's Evaluation & Recommendation.**

- S7a. Certification of supervision.

- S7b. MD/DO Last Name.

- S7c. MD/DO License #.

Validated against the Texas Medical Board (TMB) file. The address on file with the TMB is the address used to send the physician letters (i.e., denial letters).

- S7c1. MD/DO License State.

- S7d. MD/DO Military Spec Code #.

**Note:** *The physician's licensing information is a vital piece of information. Therefore, the physician's license number or Military Specialty Code will be required on all MN and LOC submissions, regardless of the Reason for Assessment (AA8a). Providers must enter the appropriate information into either field S7c MD/DO License # or Field S7d MD/DO Military Spec Code # for an MN and LOC Assessment to be successfully submitted.*

- S7e. Physician's Signature on File.

**Note:** *Providers may indicate that the physician signature is on file by checking the box in field S7e. The Physician's Signature page is available for use on all assessments, but is only required when completing an Initial Assessment (01) on the MN and LOC Assessment.*

- **S8. Comments.**

The comments field allows up to 500 characters to be added. It is essential that you include signs and symptoms that present an accurate picture of the individual's condition. The "Comments" section can be used for additional qualifying data that indicates the need for skilled nursing care, such as:

- Pertinent medical history.
- Ability to understand medications.
- Ability to understand changes in condition.
- Abnormal vital signs.
- Previous attempts at outpatient management of medical condition.
- Results of abnormal lab work.

# Definition of Medical Necessity and the MN Determination Process

## Definition of Medical Necessity

Medical necessity (MN)--The determination that a recipient requires the services of licensed nurses in an institutional setting to carry out the physician's planned regimen for total care. A recipient's need for custodial care in a 24-hour institutional setting does not constitute a medical need. A group of health care professionals employed or contracted by the state Medicaid claims administrator contracted with HHSC makes individual determinations of medical necessity regarding nursing facility care. These health care professionals consist of physicians and registered nurses. – 40 TAC 19.101 #73

## The Differences in Licensed Nurse Needs and Custodial Care

**Custodial care** is identified as care given by nurses' aides or lay caregivers that provide safety and/or assistance with activities of daily living such as: bathing, toileting, eating, dressing and ambulation/mobility.

**Licensed nurse needs** are defined as skills provided by licensed nursing personnel to assess, plan, supervise, and provide treatment on a regular basis. To include, but are not limited to, observation; promotion and maintenance of health; prevention of illness and disability; management of health-care services during acute and chronic phases of illness; guidance and counseling of individuals and families; and referral to physicians, other health-care providers, and community resources when appropriate.

## General Qualifications for Medical Necessity Determinations

Medical necessity is the prerequisite for participation in the Medicaid (Title XIX) Long Term Care program. This section contains the general qualifications for a medical necessity determination. To verify that medical necessity exists, an individual must meet the conditions described in paragraphs (1) and (2) of this section. – 40 TAC 19.2401

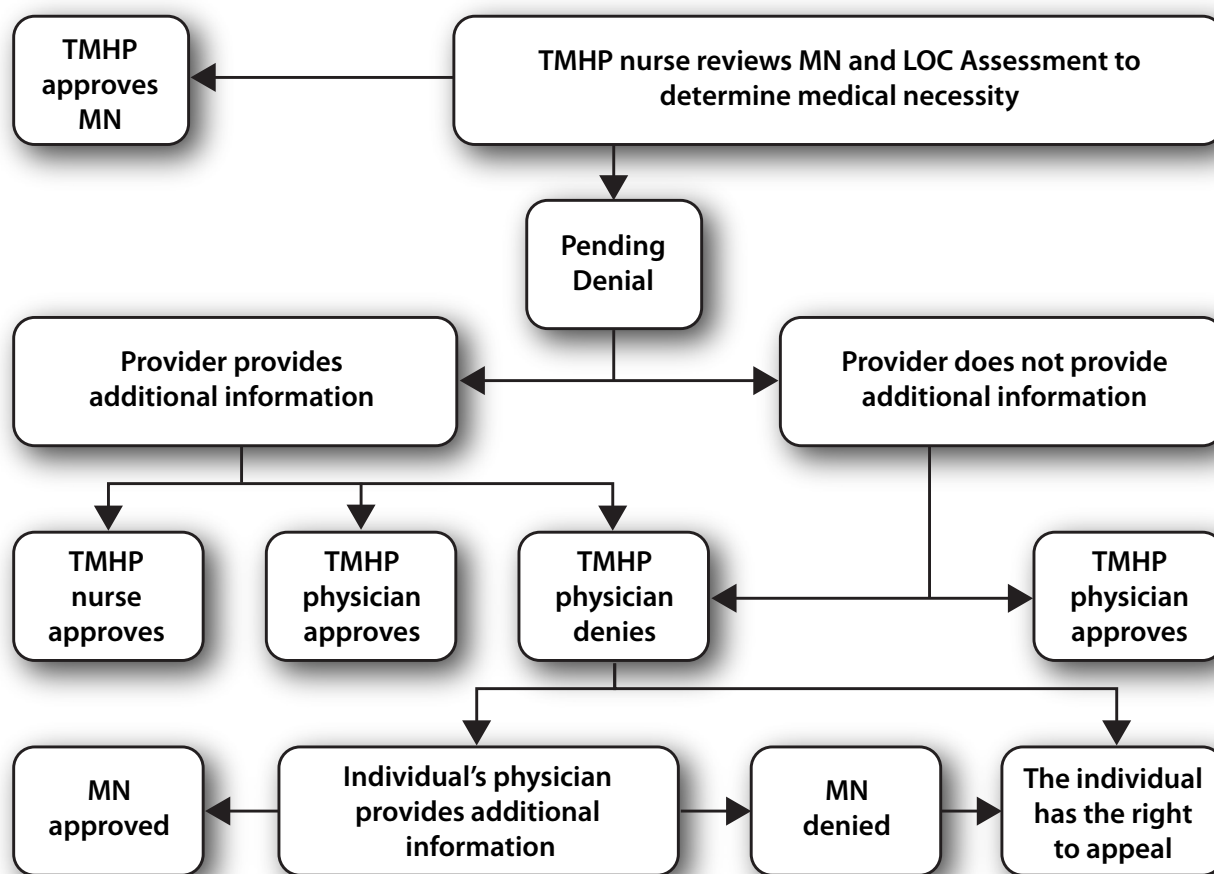
1. The individual must demonstrate a medical condition that:
  - (A) is of sufficient seriousness that the individual's needs exceed the routine care which may be given by an untrained person; and
  - (B) requires licensed nurses' supervision, assessment, planning, and intervention that are available only in an institution.

2. The individual must require medical or nursing services that:

- (A) are ordered by the physician;
- (B) are dependent upon the individual's documented medical conditions;
- (C) require the skills of a registered nurse or licensed vocational nurse;
- (D) are provided either directly by or under the supervision of a licensed nurse in an institutional setting; and
- (E) are required on a regular basis.

**Note:** MN is only one of the criteria that must be met as a prerequisite for LTC Medicaid Waiver programs.

## Medical Necessity Determination Process



This flowchart provides a high level overview of the process used for determination of MN.

1. The assessments are reviewed by the TMHP nurse within three business days to determine MN.

TMHP systems automatically review specific criteria on the assessments. If the criteria are appropriately met, the assessment is automatically approved. If not, the provider will see "The Form has failed Auto MN Approval" displayed in the History trail of the assessment. The assessment will then be sent to a nurse for manual MN review. The assessment will be set to status "Pending Review" on the FSI search results; however, the last message showing in the History trail will be "The Form has failed Auto MN Approval."



2. Once reviewed, the assessment is either approved (meeting MN) or set to status “Pending Denial (need more information)” for up to 21 days. FSI or Current Activity will allow the provider to view the status of an assessment during the MN determination process.
3. The provider may supply additional information clarifying nursing/medical needs through the “Add Note” feature on the LTC Online Portal or by calling TMHP and speaking with a TMHP nurse.
4. If the TMHP nurse determines that MN has been met, the assessment is approved.
5. If the TMHP nurse still cannot determine any licensed nursing need, the individual’s assessment is sent to the TMHP physician for an MN determination.
6. If the TMHP physician determines that MN has been met, the assessment is approved.
7. If the MN is denied by the TMHP physician, notification of denied MN is sent to the individual and the physician of record via mail. The provider will have access to the status of the assessment via the Form Status Inquiry/Current Activity on the LTC Online Portal.
8. The attending physician may respond within 14 calendar days of the date of the denial letter by faxing or calling TMHP with additional medical information (40 TAC 19.2407). Or, a licensed nurse familiar with the individual may provide additional information by calling and speaking with a TMHP nurse.
9. If the TMHP physician or nurse determines that MN has been met, the assessment is approved.
10. If the TMHP physician determines that MN has not been met, the denial is upheld.
11. If the provider does not provide additional information clarifying nursing/medical needs within the 21 days of “Pending Denial (need more information)” status, the assessment is sent to the TMHP physician for review, and steps 7-11 will apply.
12. The individual may initiate the appeal process when notified by a DADS worker via the form 2065C, that MN has been denied by TMHP physician. If a hearing is requested, additional information may be submitted at any time by the provider or by the individual’s physician either via a phone call to the TMHP nurses or via fax.

**Note:** *At any point, providers can check the status of the assessment and the MN determination for the assessment by utilizing the LTC Online Portal features of FSI or Current Activity.*

## Request for Fair Hearing

Waiver individuals may request to appeal a denial through their DADS caseworker. The DADS caseworker initiates the appeal process by notifying the Fair Hearing Officer. The caseworker completes a DADS Fair Hearing Request Summary (Form 4800-D) which notifies the Fair Hearing Officer of the request. The Fair Hearing Officer will then contact the TMHP Fair Hearing Department with the hearing date and time. The provider will be notified of the hearing date and time by the Fair Hearing Officer.

**Note:** *The process for waiver managed care members and the HMOs to follow is included in the Uniform Managed Care Contract.*

# Assessment Status

Providers can monitor the status of their MN and LOC Assessment by utilizing FSI or Current Activity on the LTC Online Portal. Once a specific assessment is selected, the status can be located at the bottom of the assessment in the History trail, the top of the page, and within the FSI or Current Activity results. The following are statuses that a provider may see, and their definition:

- **Appealed:** The assessment was previously denied and the individual or their representative has requested a fair hearing.
- **Approved:** MN has been determined and approved.
- **Corrected:** This assessment has been corrected by the submitting provider. There will be a new DLN located in the History trail indicating the replacement DLN for the corrected assessment. No further actions allowed on assessment with a status of corrected.
- **Denied:** The assessment has been reviewed by the TMHP doctor who has determined that the information did not support MN.
- **Escalated Needs Review:** The assessment has been escalated to a DADS worker for review.
- **Form Inactivated:** This assessment has been inactivated by the submitting provider. No further action may be allowed on this assessment.
- **ID Invalid:** Medicaid ID validation failed. Contact the Medicaid Eligibility Worker to verify the individual's name, Social Security Number, and Medicaid ID. A new assessment with the correct information will need to be submitted.
- **Invalid/Complete:** Per DADS, this assessment has been deemed invalid. The reason can be found in the History trail. A new assessment must be submitted with the correct information.
- **Med ID Check Inactive:** Medicaid ID validation attempted nightly for up to 6 months and failed or the request was cancelled. Provider may restart the assessment once the reason for failed validation has been resolved by the Medicaid Eligibility Worker by clicking the "Restart Form" button.
- **Medicaid ID Pending:** Medicaid ID validation is pending. Validation attempts occur nightly until deemed valid, invalid or until 6 months has expired, whichever comes first. Contact the Medicaid Eligibility Worker to verify the individual's name, Social Security Number, and Medicaid ID.
- **Out of State RN License Invalid:** TMHP has performed a manual check on the out-of-state license and determined it to be invalid. This often happens because the provider entered the wrong state. If the information on the assessment is incorrect, the provider can submit a correction within 14 days of submission to fix the erroneous information.
- **Overtaken Doctor Review:** Assessment was denied MN, and the provider has supplied additional information for review. The assessment is pending TMHP Doctor review for MN determination.
- **Pending Denial (need more information):** The assessment has been reviewed for MN by a TMHP RN. The information did not support MN. The provider has up to 21 days to supply additional information for consideration either via phone or the "Add Note" feature.
- **Pending More Info:** DADS is waiting for more information from the provider. Information required may be found within the assessment History trail.

- **Pending Review:** Assessment is waiting for TMHP RN to manually review it for MN.
- **Pending RN License Verification:** RN License number is pending manual verification by TMHP from the Texas Board of Nursing or the licensing state from which the compact license was issued.
- **Processed/Complete:** Assessment has been processed and complete. Please check MESAV.
- **Provider Action Required:** Assessment must be reviewed by the provider due to the assessment being Rejected by Service Authorization System (SAS). Refer to the assessment History trail for the specific error message. The error message must be resolved before further processing of assessment will occur.
- **SAS Request Pending:** Assessment has passed all TMHP validations and will be sent from TMHP to DADS for SAS processing. Please allow 2-4 days for the next status change.
- **Submitted to manual workflow:** Assessment has been submitted to DADS due to the assessment being Rejected by SAS. Refer the assessment History trail for additional information.

# Provider Workflow

Provider workflow allows providers to independently manage their assessments when errors in the Medicaid system processing occur. The assessments going into the provider workflow are those situations where the provider is required to take action for resolution of the problem. The provider workflow allows providers to directly manage their rejections which occurred during the Medicaid processing. The benefit to the provider is shorter time in resolution since providers can resolve their own errors.

In summary, provider workflow is:

- Assessment has not been successfully processed.
- Error occurred during system processing.
- Rejection error message can be found within the assessment History trail.
- Ownership for resolution belongs to the provider.
- Assessment is set to status “Provider Action Required.”

It is the responsibility of the provider to monitor and manage the provider workflow. Assessments are placed in the provider workflow as a result of the Medicaid system processing discovering an error while attempting to process the assessment. System processing errors are found within the History trail of the assessment and the assessment is set to status “Provider Action Required.” Once an assessment is set to status “Provider Action Required,” the assessment will require provider action before processing on that particular assessment continues.

If a system error occurs, the error will display in the History trail of the assessment. The assessment is set to status “Provider Action Required.”

## Finding Assessments with “Provider Action Required” Status

To find the items in your provider workflow (i.e., those items with system processing errors to be resolved by the provider):

1. Click the **Form Status Inquiry** link in the blue navigational bar.
2. Choose Type of Form: **Waiver: Medical Necessity and Level of Care Assessment** from the drop-down box.

The screenshot shows the 'Form Status Inquiry' page of the Texas Medicaid & Healthcare Partnership (TMHP) A State Medicaid Contractor. The page has a blue header with navigation links: Home, Submit Form, Form Status Inquiry (selected), Current Activity, My Drafts, Printable Forms, and Help. Below the header, the 'Form Select' section contains two dropdown menus. The first, 'Type of Form', is set to 'Waiver: Medical Necessity and Level of Care Assessment'. The second, 'Vendor Number', is also set to 'Waiver: Medical Necessity and Level of Care Assessment'. The 'Form Status Inquiry' section below contains several input fields: DLN, Last Name, SSN, From Date (3/2/2009), Purpose Code, Reason for Assessment, Medicaid Number, First Name, Form Status (dropdown), and To Date (4/1/2009). The page is displayed in a browser window with a blue border.

3. Enter the “From Date” and “To Date” range Form Status: Choose **Provider Action Required** from the drop-down box.

**Form Status Inquiry**

**Form Select**

Type of Form Waiver: Medical Necessity and Level of Care Assessment

Vendor Number for Contract Number

**Form Status Inquiry**

DLN

Last Name

SSN --

From Date 3/2/2009

Purpose Code

Reason for Assessment

Medicaid Number

First Name

Form Status

To Date

Appealed

Approved

Corrected

Denied

Escalated Needs Review

Form Inactivated

ID Invalid

Invalid/Complete

Med ID Check Inactive

Medicaid ID Pending

Out of State RN License Invalid

Overturned Doctor Review

Pending Denial (need more information)

Pending More Info

Pending Review

Pending RN License Verification

Processed/Complete

**Provider Action Required**

CAS Request Pending

Submitted to manual workflow

4. Click the “Search” button located on the bottom right of the screen.

**Form Status Inquiry**

**Form Select**

Type of Form Waiver: Medical Necessity and Level of Care Assessment

Vendor Number for Contract Number

**Form Status Inquiry**

DLN

Last Name

SSN --

From Date 3/21/2009

Purpose Code

Reason for Assessment

Medicaid Number

First Name

Form Status Provider Action Required

To Date 4/6/2009

5. All Waiver: Medical Necessity and Level of Care Assessments that are set to status “Provider Action Required” will display.

**Note:** For confidentiality purposes, the assessment details (i.e., Medicaid #, etc.) have been hidden in this document.

Type of Form: Waiver: Medical Necessity and Level of Care Assessment

Vendor Number: 1232 For Confidential Number: 00123456

**Form Status Inquiry**

DLN:  Medicaid Number:

Last Name:  First Name:

SSN:  Form Status: Provider Action Required

From Date: 3/2/2009 To Date: 4/1/2009

Purpose Code:

Reason for Assessment:

1 record(s) returned.

	DLN	TMHP Received Date	SSN	Medicaid #	Medicare #	First Name	Last Name	Status	RUG	RN Signature Date	Purpose Code	Contr Num
<a href="#">View Detail</a>	000000000000	3/4/2009	000000000000	000000000000	000000000000	000000000000	000000000000	Provider Action Required	000	3/4/2009		000000000000

6. Click the **View Detail** link to open the assessment.
7. Scroll to the bottom of the page to view the History trail.

Assessment: a. Primary reason for assessment  
1. Admission assessment

**History**

Form Submitted	3/4/2009 4:41:34 PM
Pending Review	3/4/2009 4:41:35 PM
3/4/2009 4:41:35 PM	TMHP: The form has failed Auto-MN Approval
Pending Denial (need more information)	3/4/2009 5:54:53 PM
3/5/2009 9:40:25 AM	TMHP: PER ASSESSMENT NURSE: CLT HAS SKILLED NURSING AGENCY TO RECORDS WORKBOOKS WHEN CLT HAS LOOSE STOOLS AND SOLES THE CHAIRS/STOOLS LEFT BUT TOOK STAGE 2 WORKING APPROX ONE INCH SQUARE RIGHT BUT TOOK LILTS IS SMALLER AND AT STAGE 1
Pending Review	3/5/2009 9:40:25 AM
3/5/2009 9:40:25 AM	TMHP: Form notes have been updated. Form has been re-submitted for nurse review
Pending Denial (need more information)	3/5/2009 11:17:43 AM
3/5/2009 11:45:49 AM	TMHP: PER ASSESSMENT NURSE: CLT HAS SKILLED NURSING TO RECORDS WORKBOOKS WHEN CLT HAS LOOSE STOOLS AND SOLES THE CHAIRS/STOOLS LEFT BUT TOOK STAGE 2 WORKING APPROX ONE INCH SQUARE RIGHT BUT TOOK LILTS IS SMALLER AND AT STAGE 1. CLT SELF CATHES Q 2-3 HRS. DASH 14 FEB 14 FOR GRAFT. IN OBSCURIOUS HOSPITAL PARTS IN DEC DEPARTMENT OF 8 DECUB
Approved	3/5/2009 2:37:20 PM





- **Inactivate Form.** “Inactivate Form” will deactivate the assessment. The status of the assessment will then set to status “Form Inactivated.” An example of when this “Inactivate Form” button would be used is when the provider research indicates the assessment being submitted is a duplicate.
- **Resubmit Form.** “Resubmit Form” will set assessment to status “SAS Request Pending.” The assessment will process during the nightly system processing. Check the status of the assessment the next day to determine if the assessment processed successfully. The assessment will be set to status “Processed/Complete” if successfully processed.

**TMHP** TEXAS MEDICAID & HEALTHCARE PARTNERSHIP  
A STATE MEDICAID CONTRACTOR

Home Submit Form Form Status Inquiry Current Activity My Drafts Printable Forms Help

**MEDICAL NECESSITY AND LEVEL OF CARE ASSESSMENT**

Current Status: Provider Action Required Resident Name: DLN: RUG:CA1

**Form Actions:** Print Print Physician's Signature Use as template Add Note Inactivate Form

**Workflow Actions:** Resubmit Form

Section AA. Section A. Section B. Section C. Section D.  
Section E. Section G. Section H. Section I. Section J.  
Section K. Section M. Section N. Section O. Section P.  
Section Q. Section R. Section LTCMI. Section U.

**SECTION AA: IDENTIFICATION INFORMATION**

1. Individual Name a. (First) b. (Middle Initial) c. (Last) d. (Suffix Jr/Sr)

2. Gender 2. Female

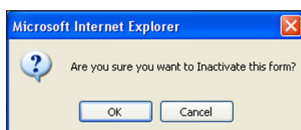
3. Birth date

4. Race/Ethnicity 4. Hispanic

5. Social Security and Medicare Numbers. a. Social Security Number

12. If the provider chooses “Correct this form,” the provider will complete a new assessment. The original assessment that was in the status of “Provider Action Required” will be set to status “Corrected” with a parent relationship DLN to the new/child assessment. The new assessment replaces the original assessment.

If the provider chooses “Inactivate Form,” the provider will receive the following confirmation window.



Click the “OK” button to Inactivate, and the assessment will set to status “Form Inactivated.” Click the “Cancel” button to cancel the Inactivation request keeping the assessment set to status “Provider Action Required.”

If the provider chooses “Resubmit Form,” the following screen will appear allowing the provider to add any comments.

**TEXAS MEDICAID & HEALTHCARE PARTNERSHIP**  
**TMHP** A STATE MEDICAID CONTRACTOR

Home Submit Form Form Status Inquiry Current Activity My Drafts Printable Forms Help

UnLock Form

**MEDICAL NECESSITY AND LEVEL OF CARE ASSESSMENT**

Current Status: Provider Action Required Resident Name: DLN: RUG: CA1

Form Actions: Print Print Physician's Signature Use as template Add Note Inactivate Form **Workflow Actions: Resubmit Form**

Section AA.	Section A.	Section B.	Section C.	Section D.
Section E.	Section G.	Section H.	Section I.	Section J.
Section K.	Section M.	Section N.	Section O.	Section P.
Section Q.	Section R.	Section LTCMI.	Section U.	

**SECTION AA: IDENTIFICATION INFORMATION**

1. Individual Name a. (First) M b. (Middle Initial) c. (Last) d. (Suffix Jr/Sr)

2. Gender 2. Female

3. Birth date

4. Race/Ethnicity 4. Hispanic

5. Social Security and Medicare Numbers. [Either Social Security Number or Medicare Number is required.]  
 a. Social Security Number  
 b. Medicare number (or comparable railroad insurance number)

There is an option to select “2-System” or “1-ProviderFacing.”

- **2-System:** will allow comments entered by the provider to be seen only by internal state staff. The comments will not be able to be seen by the provider.
- **1-ProviderFacing:** will allow comments entered to be seen by both state staff and the provider.

In either case, the comments will be seen in the History trail of the assessment.

The provider may choose to enter comments. Entering comments is optional.

Click the “Cancel” button to cancel the request, keeping the assessment set to status “Provider Action Required.”

or

Click the “Change Status” button to move the assessment out of the “Provider Action Required.”

Change Status for form [XXXXXXXXXX] to Submit to SAS Enter the notes below:  
 If you would like the provider to see the note, please select the provider facing option from the list below.

1-ProviderFacing  
 2-System  
 1-ProviderFacing

Cancel Change Status

13. Once one of the actions has been completed by “Correct this form,” “Inactivate Form,” or “Resubmit Form,” the assessment will no longer be set to status “Provider Action Required.”

## Provider Workflow Rejection Messages

Below are the rejection messages providers will receive as a result of an error occurring during the nightly system processing. The messages are in order of message number.

The table contains 4 columns:

1. **Message Number.** This is the specific error message that will be displayed in the portal.
2. **System Message.** Further clarification of the portal error message including basic example of the situation.
3. **Associated with Reason for Assessment.** What assessment type can result in the error.
  - a. **AA8a = 01.** Initial Assessment
  - b. **AA8a = 02.** Annual Assessment
  - c. **AA8a = 03.** Significant Change in Status Assessment
4. **Suggested Action.** Most likely the Workflow Action Button to be used.

Reject Message Description			
Message Number	System Message (Displayed in History)	Associated with Reason for Assessment	Suggested Action
CS-0001	CS-0001: The request cannot be processed because an existing Initial assessment (01) has already been processed. Please contact the case manager or submit an Annual assessment (02), or SCSA (03) as appropriate.	AA8a = 01	The request cannot be processed because an existing Initial assessment has already been processed. Please contact the case manager or inactivate the Initial assessment and submit an Annual Assessment (or SCSA) as appropriate.
CS-0003	CS-0003: The request cannot be processed because the Annual assessment (02) is being submitted more than 90 days prior to the Service Plan end date. Please resubmit the assessment at the appropriate time.	AA8a = 02	Inactivate Form and submit annual when within the 90 days.
CS-0004	CS-0004: The request cannot be processed because the Annual assessment (02) has been submitted more than 132 days after the end of the last Service Plan. Please submit an Initial assessment (01).	AA8a = 02	The request cannot be processed because the Annual assessment has been submitted more than 132 days after the end of the last Service Plan. Inactivate Annual Assessment and submit an Initial Assessment.
CS-0005	CS-0005: The request cannot be processed because a previous Service Plan cannot be found. Please submit an Initial assessment (01).	AA8a = 02	The request cannot be processed because a previous Service Plan cannot be found. Please submit an Initial assessment.
CS-0006	CS-0006: The request cannot be processed because an Initial assessment (01) for the individual cannot be found. Please verify data entry or contact the case manager.	AA8a = 03	The request cannot be processed because an Initial assessment for the individual cannot be found. Please verify data entry or contact the case manager.

Reject Message Description			
Message Number	System Message (Displayed in History)	Associated with Reason for Assessment	Suggested Action
CS-0011	CS-0011: The request cannot be processed because there is not an open Service Plan for the individual. Please verify data entry or contact the case manager.	AA8a = 03	Inactivate Form.
CS-0012	CS-0012: The request cannot be processed because the SCSA assessment (03) is being submitted more than 30 days after the Service Plan end date.	AA8a = 03	Inactivate Form.

# Corrections

If incorrect data is submitted on the MN and LOC Assessment, the provider can submit a correction within 14 calendar days of the original submission by clicking the “Correct this form” button. However, not all fields are correctable (see list of fields unable to be corrected in the “Provider Workflow” section).

Examples of incorrect data are:

- Individual is listed as a male, but is actually a female.
- Individual’s diagnosis indicates diabetes, but the individual actually has hypoglycemia.

If corrections to the MN and LOC Assessment are needed, providers must access the assessment utilizing FSI or Current Activity.

## When to correct assessment?

When data submitted is incorrect.

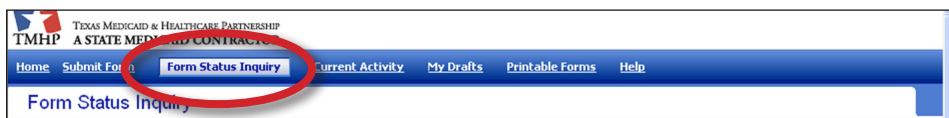
## Who may submit the correction?

It does not have to be the original submitter, but it has to be from the same vendor/contract number. Regardless of the current status of an MN and LOC Assessment, corrections will not be allowed to assessments that have at any time been set to status “Form Inactivated” or “Invalid/Complete.” The “Correct this form” button will not be displayed in the yellow Form Actions bar on any form that cannot be corrected. Also, corrections are processed overnight, and providers must wait until the following day to see changes.

**Note:** *The DADS Nurse acts as a provider when submitting the MN and LOC Assessment.*

## How to Submit a Correction

1. Click the **Form Status Inquiry** link in the blue navigational bar.



2. Type of Form: Choose **Waiver: Medical Necessity and Level of Care Assessment** from the drop-down box.
3. Enter data for all required fields as indicated by the red dots. Narrow results by entering specific criteria in the additional fields: “DLN,” “Last Name,” “First Name,” “SSN,” “Medicaid Number,” “Form Status,” “From Date,” and “To Date.”
4. Click the “Search” button.

5. Click the **View Detail** link of the requested assessment.

Vendor Number  for Contract Number

**Form Status Inquiry**

DLN  Medicaid Number   
 Last Name  First Name   
 SSN  Form Status   
 From Date  To Date   
 Purpose Code   
 Reason for Assessment

50 record(s) returned.  
 Not all records returned. This search is limited to return 50 records. Please narrow your search.

	DLN	TMHP Received Date	SSN	Medicaid #	Medicare #	First Name	Last Name	Status	RUG	RN Signature Date	P
<a href="#">View Detail</a>	11/4/2009 2:36:03 PM	11/4/2009 2:36:03 PM	11/4/2009 2:36:03 PM	11/4/2009 2:36:03 PM	11/4/2009 2:36:03 PM	11/4/2009 2:36:03 PM	11/4/2009 2:36:03 PM	11/4/2009 2:36:03 PM	11/4/2009 2:36:03 PM	11/4/2009 2:36:03 PM	11/4/2009 2:36:03 PM
<a href="#">View Detail</a>	11/4/2009 2:36:06 PM	11/4/2009 2:36:06 PM	11/4/2009 2:36:06 PM	11/4/2009 2:36:06 PM	11/4/2009 2:36:06 PM	11/4/2009 2:36:06 PM	11/4/2009 2:36:06 PM	11/4/2009 2:36:06 PM	11/4/2009 2:36:06 PM	11/4/2009 2:36:06 PM	11/4/2009 2:36:06 PM
<a href="#">View Detail</a>	11/4/2009 2:36:06 PM	11/4/2009 2:36:06 PM	11/4/2009 2:36:06 PM	11/4/2009 2:36:06 PM	11/4/2009 2:36:06 PM	11/4/2009 2:36:06 PM	11/4/2009 2:36:06 PM	11/4/2009 2:36:06 PM	11/4/2009 2:36:06 PM	11/4/2009 2:36:06 PM	11/4/2009 2:36:06 PM
<a href="#">View Detail</a>	11/4/2009 2:36:06 PM	11/4/2009 2:36:06 PM	11/4/2009 2:36:06 PM	11/4/2009 2:36:06 PM	11/4/2009 2:36:06 PM	11/4/2009 2:36:06 PM	11/4/2009 2:36:06 PM	11/4/2009 2:36:06 PM	11/4/2009 2:36:06 PM	11/4/2009 2:36:06 PM	11/4/2009 2:36:06 PM

6. Click the “Correct this form” button.

**MEDICAL NECESSITY AND LEVEL OF CARE ASSESSMENT**

Current Status: Pending Review Resident Name:  DLN:  RUG: IB1  
 Note: Waiver correction are not allowed after 14 days of submit date logged in history.

**Form Actions:**

7. Complete only the fields needing correction.
8. Click the “Submit Form” button.
9. The original assessment (parent) is set to status “Corrected” and the new assessment (child) DLN is assigned, creating the parent/child DLN relationship. The new child assessment replaces the parent assessment.

History	
Form Submitted	11/4/2009 2:36:03 PM
Pending Review	11/4/2009 2:36:06 PM
11/4/2009 2:36:06 PM	TMHP : The patient is under 21
Corrected	11/4/2009 2:42:43 PM
11/4/2009 2:42:43 PM	provider_ext52 : Form has been corrected by DLN <input type="text"/>

**MEDICAL NECESSITY AND LEVEL OF CARE ASSESSMENT**

Current Status: Pending Review Resident Name:  DLN:  RUG: IB1  
 Parent DLN:   
 Note: Waiver correction are not allowed after 14 days of submit date logged in history.

**Form Actions:**

**Section A.** **Section B.** **Section C.** **Section D.**

## Inactivations

MN and LOC Assessments may be inactivated. Assessments may need to be inactivated when fields cannot be corrected as needed. (i.e., Medicaid #, Individual Name). MN and LOC Assessments can be inactivated through the LTC Online Portal by first retrieving the assessment using FSI or Current Activity.

### When to inactivate?

An assessment needs to stop processing in the workflow, or if an assessment needs to be cancelled, if already processed to completion.

### Who may inactivate?

It does not have to be the original submitter, but it has to be inactivated from the same vendor/contract number.

Inactivations may be performed based on the vendor/contract who submitted the assessment originally. None of the DADS or TMHP teams (Community Services [CS] Workers, CS Team Leads, TMHP Operations) may submit an inactivation on an MN and LOC Assessment. There is no time limitation to perform an inactivation, and assessments are set to status “Form Inactivated.” Once the assessment is inactivated, however, it can be used as a template, and a new assessment may be submitted.

The screenshot shows the TMHP (Texas Medicaid & Healthcare Partnership) A STATE MEDICAID CONTRACTOR portal. The top navigation bar includes links for Home, Submit Form, Form Status Inquiry, Current Activity, My Drafts, Printable Forms, and Help. The main content area displays the 'MEDICAL NECESSITY AND LEVEL OF CARE ASSESSMENT' form. The current status is 'Processed/Complete' and the resident name is 'DLN'. The form is divided into sections A through U. The 'Form Actions' bar includes buttons for Print, Print Physician's Signature, Use as template, Add Note, and Inactivate Form. The 'Inactivate Form' button is circled in red. A confirmation dialog box is displayed over the form, asking 'Are you sure you want to Inactivate this form?' with OK and Cancel buttons.

To inactivate an assessment:

1. Login to the LTC Online Portal.
2. Find your document using FSI or Current Activity.
3. Click the **View Detail** link.
4. Click the “Inactivate Form” button.

5. When the dialog box stating “Are you sure you want to Inactivate this form?” appears:

- a. Click the “OK” button to inactivate the assessment.

**or**

- b. Click the “Cancel” button if you do not want to inactivate the assessment.

**Note:** *Once inactivated, assessments cannot be reactivated and assessment will be set to status “Form Inactivated.”*

## How to Correct BC1 RUG

A BC1 RUG is due to an out-of-range value on an assessment and will result in the lowest default RUG. The TMHP LTC Online Portal will not accept an MN and LOC Assessment with a calculated BC1 RUG. All fields known to cause the BC1 RUG will need to be resolved before the assessment will submit successfully.

The screenshot shows a web form titled "MEDICAL NECESSITY AND LEVEL OF CARE ASSESSMENT". At the top, a red dashed box contains an error message: "This assessment has produced a RUG of BC1, which is not valid for this program, and has not been accepted on the Portal. Please review the RUG fields for accuracy; then correct and resubmit. Click on the Help link in the Navigation Bar to view the Item by Item Guide as needed." Below the message, the form displays "Current Status: Resident Name: [REDACTED] RUG:SSA" and "Parent DLN: [REDACTED]". A yellow bar labeled "Form Actions:" contains buttons for "Print", "Print Physician's Signature", and "Save as Draft". The main body of the form is a grid of sections: Section AA., Section A., Section B., Section C., Section D., Section E., Section G., Section H., Section I., Section J., Section K., Section M., Section N., Section O., Section P., Section Q., Section R., Section LTCMI., and Section U. The "Section LTCMI." header is highlighted in blue.

To resolve your BC1, validate the following assessment fields fall within the look-back period of seven days:

- E. Behavioral Symptoms.
  - E.4a – e (A) Behavioral Frequency.
  - E.4a – e (B) Behavioral Alterability.
- J. Health Conditions.
  - J.1a – p Indicators.
- O. Medications.
  - 0.3 Injections.
  - 0.4 Days Received the Following Medication.
- P. Special Treatments and Procedures.
  - P.1b (A) Therapies Days.
  - P.1b (B) Therapies Minutes.
  - P.3 Nursing Rehabilitation/Restorative Care.

The following assessment fields should fall within the look-back period of 14 days:

- P. Special Treatments and Procedures.
  - P.7 Physician Visits.
  - P.8 Physician Orders.



# RUG Training Requirements

Resource Utilization Group (RUG) training is intended for LTC nurses, and providers associated with the DADS Community Programs. RUG training is designed to provide providers the requirements for completing RUG fields in assessments for Texas Medicaid reimbursement.

Texas State University, in cooperation with the HHSC Office of Inspector General (OIG) has made this training available through the Office of Continuing Education's online course program.

To register for the RUG training, or for more information visit:

[www.txstate.edu/continuinged/programs/Online-Programs/RUG-Training.html](http://www.txstate.edu/continuinged/programs/Online-Programs/RUG-Training.html)

RUG training is valid for 2 years then it must be renewed by completing the online RUG training via Texas State University.

RUG training is required for RNs who sign assessments as complete. The RN license number listed on section S5 of the LTCMI is validated for completion of RUG training. An error will occur if the license number does not pass validation. The assessment will not be considered successfully submitted until all errors are resolved.

Texas State University RUG training can take 2-7 working days (M-F, 8-5) to process and report completions of RUG training to TMHP, depending on current volume of enrollments and completions.

## RUG Worksheet and Definitions

To view the RUG worksheet and definition for each RUG classification, go to

<http://tinyurl.com/TMHP-LTC-RUG-Worksheet>

# Reminders

- Utilize FSI and Current Activity. These features will keep you informed of the status of your assessments.
- Print and sign the assessment prior to submission.
- Provide pertinent information in the “Comments” section.
- Submit additional information, within 21 days, through the LTC Online Portal or call when the assessment is set to status “Pending Denial (need more information).”
- All RN and MD/DO licenses will be validated against the Texas Board license files for successful submission.
- Use the TMHP website at [www.tmhp.com/LTC Programs](http://www.tmhp.com/LTC%20Programs) for recent updates and new information.
- For step-by-step instructions on how to use the various features of the LTC Online Portal, providers may also refer to the Online Portal User Manual for LTC Community Waiver Providers at:  
<http://tinyurl.com/LTC-Waiver-Portal-Manual>

# Preventing Medicaid Fraud

Medicaid fraud: “An intentional deceit or misrepresentation made by a person with the knowledge that deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law.”

## How to Report Waste, Abuse and Fraud

Reports may be made through the following website: <https://oig.hhsc.state.tx.us>. This website also gives instructions on how to submit a report, as well as, how to submit additional documentation that cannot be transmitted over the Internet. The website also provides information on the types of waste, abuse and fraud to report to OIG.

If you are not sure if an action is waste, abuse, or fraud of Texas Medicaid, report it to OIG and let the investigators decide. If you are uncomfortable about submitting a report online, there is a phone number for Client Fraud and Abuse reporting: **1-800-436-6184**.

# HIPAA Guidelines and Provider Responsibilities

Providers must comply with the *Health Insurance Portability and Accountability Act* (HIPAA) of 1996. It is YOUR responsibility to comply with HIPAA, to seek legal representation when needed, and to consult the manuals/speak to representatives when you have questions.

# Contact Information

## TMHP Call Center/Help Desk

Telephone.....**1-800-727-5436/1-800-626-4117**

Fax.....**1-512-514-4223**

General Inquiries: Press 1

Medical Necessity: Press 2

Technical Support: Press 3

Audio Message Paper Submitters: Press 4

Medicaid Hotline.....**1-800-252-8263**

RUG Training Information .....**1-512-245-7118**

EDI Help Desk.....**1-888-863-3638**

LTC Helpdesk.....**1-800-626-4117**

TMHP General Customer Service.....**1-800-925-9126**

Medicaid Fraud.....**1-800-436-6184**

## Community Based Alternatives Program Contacts

Completing the MN and LOC Assessment:

Contact your Regional Nurse..... [www.dads.state.tx.us/providers/CBA/contacts.html](http://www.dads.state.tx.us/providers/CBA/contacts.html)

## Consolidated Waiver Program Contacts

Completing the MN and LOC Assessment: ..... **512-438-3444**

## Medically Dependent Children Program Contacts

Completing the MN and LOC Assessment: Contact the RLS State Office Nurse: ..... **512-438-5837**

## Integrated Care Management

Business Rules Questions: .....**512-438-3169** or email [Heather.Powell@hhsc.state.tx.us](mailto:Heather.Powell@hhsc.state.tx.us)

## PACE Program Contacts

Completing the MN and LOC Assessment: ..... **512-438-2489**

## STAR+PLUS Program Contacts

Business Rule Questions: .....Contact [David.Johnson@hhsc.state.tx.us](mailto:David.Johnson@hhsc.state.tx.us)

Questions regarding Medical Necessity Determinations: Contact the Texas Medicaid & Healthcare Partnership at **1-800-727-5436**

## DADS Regional Nurse Contact Information

Region	Phone Number
Region 1/10	1-915-834-7566
Region 2/9	1-325-795-5725
Region 3	1-940-320-8249
Region 4	1-903-737-0226
Region 5	1-409-383-5531
Region 6	1-713-967-7678
Region 7	1-254-750-9268
Region 8	1-210-438-6216
Region 11	1-956-983-7645

## Informational Websites

Centers for Medicare and Medicaid Services	<a href="http://www.cms.hhs.gov">www.cms.hhs.gov</a>
Community Care Programs	<a href="http://www.dads.state.tx.us/providers/index.cfm">www.dads.state.tx.us/providers/index.cfm</a>
Consumer Rights and Services (includes information about how to make a complaint)	<a href="http://www.dads.state.tx.us/services/crs/index.html">www.dads.state.tx.us/services/crs/index.html</a>
DADS Services	<a href="http://www.dads.state.tx.us/services">www.dads.state.tx.us/services</a>
Health and Human Services Commission	<a href="http://www.hhsc.state.tx.us">www.hhsc.state.tx.us</a>
HHSC Regions	<a href="http://www.hhs.state.tx.us/aboutHHS/HHS_Regions.shtml">www.hhs.state.tx.us/aboutHHS/HHS_Regions.shtml</a>
Long Term Care Policies	<a href="http://www.dads.state.tx.us/providers/index.cfm">www.dads.state.tx.us/providers/index.cfm</a>
Long Term Care Updates and Banner Messages	<a href="http://www.tmhp.com/LTC%20Programs">www.tmhp.com/LTC%20Programs</a>
Medicaid Fraud	<a href="https://oig.hhsc.state.tx.us/">https://oig.hhsc.state.tx.us/</a>
Medicaid Nursing Facility Program	<a href="http://www.dads.state.tx.us/providers/NF/index.cfm">www.dads.state.tx.us/providers/NF/index.cfm</a>
Medical Necessity and Level of Care Assessment and Instructions	<a href="http://tinyurl.com/MN-LOC-Assessment">http://tinyurl.com/MN-LOC-Assessment</a> <a href="http://tinyurl.com/MN-LOC-Assessment-Guide">http://tinyurl.com/MN-LOC-Assessment-Guide</a>
RUG Cost Ceiling Information	<a href="http://www.hhsc.state.tx.us/medicaid/programs/rad/lrcsvs.html">www.hhsc.state.tx.us/medicaid/programs/rad/lrcsvs.html</a>
RUG Training	<a href="http://www.txstate.edu/continuingeducation/programs/Online-Programs/RUG-Training.html">www.txstate.edu/continuingeducation/programs/Online-Programs/RUG-Training.html</a>
RUG Worksheet and Definitions	<a href="http://tinyurl.com/TMHP-LTC-RUG-Worksheet">http://tinyurl.com/TMHP-LTC-RUG-Worksheet</a>
Texas Administration Code	<a href="http://www.sos.state.tx.us/tac/index.html">www.sos.state.tx.us/tac/index.html</a>
Texas Department of Aging and Disability Services	<a href="http://www.dads.state.tx.us">www.dads.state.tx.us</a>
Texas Department of State Health Services	<a href="http://www.dshs.state.tx.us">www.dshs.state.tx.us</a>
Texas Medicaid & Healthcare Partnership (TMHP)	<a href="http://www.tmhp.com">www.tmhp.com</a>
TMHP Long Term Care Division	<a href="http://www.tmhp.com/LTC%20Programs">www.tmhp.com/LTC%20Programs</a>
TMHP LTC Online Portal User Manual for Community Waiver Providers	<a href="http://tinyurl.com/LTC-Waiver-Portal-Manual">http://tinyurl.com/LTC-Waiver-Portal-Manual</a>
Vendor Drug Program	<a href="http://www.hhsc.state.tx.us/hcf/vdp/vdpstart.html">www.hhsc.state.tx.us/hcf/vdp/vdpstart.html</a>

# Individual Plan of Care (IPC) Table

## For Community Based Alternatives (CBA) and Consolidated Waivers Program (CWP) Providers

The due dates for the annual reassessment packets submitted by Home and Community Support Services (HCSS) agencies to the case managers are listed below.

**Note:** *TMHP does not support any assessments other than the MN and LOC Assessment.*

The table below lists the reassessment due dates based on the date of the IPC expiration:

IPC Expiration Date ("To" date on IPC)	Reassessment Packet Due to Case Manager Between
January 31	November 1 - November 30
February 28 or 29	December 1 - December 31
March 31	January 1 - January 31
April 30	February 1 - February 28 or 29
May 31	March 1 - March 31
June 30	April 1 - April 30
July 31	May 1 - May 31
August 31	June 1 - June 30
September 30	July 1 - July 31
October 31	August 1 - August 31
November 30	September 1 - September 30
December 31	October 1 - October 31

# Acronyms

API	Atypical Provider Identifier
ARD	Assessment Reference Date
BON	Board of Nursing
CA	Current Activity
CBA	Community Based Alternative
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare and Medicaid Services
CS	Community Services
CSHCN ID	Children with Special Health Care Needs Identification number
CWP	Consolidated Waiver Program
DADS	Department of Aging and Disability Services
DD	Developmental Disabilities
DLN	Document Locator Number
DO	Doctor of Osteopathy
EDI	Electronic Data Interchange
FSI	Form Status Inquiry
HCSS	Home and Community Support Services
HHA	Home Health Agency
HHSC	Health and Human Services Commission
HIPAA	Health Insurance Portability and Accountability Act
HMO	Health Maintenance Organization
ICD-9	International Classification of Diseases Ninth Revision
ICM	Integrated Care Management
ID	Intellectual Disabilities
IDD	Intellectual and Developmental Disabilities
IPC	Individual Plan of Care
LTC	Long Term Care
LTCMI	Long Term Care Medicaid Information
MD	Medical Doctor
MDCP	Medically Dependent Children's Program
MESAV	Medicaid Eligibility and Service Authorization Verification

MN	Medical Necessity
MN and LOC	Medical Necessity and Level of Care
NF	Nursing Facility
NPI	National Provider Identifier
NPES	National Plan and Provider Enumeration System
OES	Office of Eligibility Services
OIG	Office of the Inspector General
PACE	Program of the All-inclusive Care for the Elderly
PCCM	Primary Care Case Management
PDF	Portable Document Format
PRN	Pro re nata (Latin) — as needed
RA	Route of Administration
R & S	Remittance and Status
R2b	Date Assessment was completed
RN	Registered Nurse
RUG	Resource Utilization Group
SAS	Service Authorization System
SCSA	Significant Change in Status Assessment
SG	Service Group
SSN	Social Security Number
STAR+PLUS	State of Texas Access Reform (STAR) + PLUS
TAC	Texas Administrative Code
TBN	Texas Board of Nursing
THCA	Texas Health Care Association
TMB	Texas Medical Board
TMHP	Texas Medicaid and Healthcare Partnership
UR	Utilization Review

# MEDICAL NECESSITY AND LEVEL OF CARE ASSESSMENT

## SECTION AA. IDENTIFICATION INFORMATION

Numeric Identifier \_\_\_\_\_

1. INDIVIDUAL NAME*	a. (First)      b. (Middle Initial)      c. (Last)      d. (Jr/Sr)		
2. GENDER*	1. Male      2. Female		
3. BIRTHDATE	<div> <div> <div></div><div></div> </div> <div>—</div> <div> <div></div><div></div> </div> <div>—</div> <div> <div></div><div></div><div></div><div></div> </div> </div> <div> <div>Month</div> <div>Day</div> <div>Year</div> </div>		
4. RACE/ETHNICITY	1. American Indian/Alaskan Native 2. Asian/Pacific Islander 3. Black, not of Hispanic origin		4. Hispanic 5. White, not of Hispanic origin
5. SOCIAL SECURITY* AND MEDICARE NUMBERS [C in 1 <sup>st</sup> box if non med. no.]	a. Social Security Number <div> <div> <div></div><div></div><div></div> </div> <div>—</div> <div> <div></div><div></div> </div> <div>—</div> <div> <div></div><div></div><div></div><div></div> </div> </div> b. Medicare number (or comparable railroad insurance number) <div> <div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div> </div>		
7. MEDICAID NO. ["+" if pending, "N" if not a Medicaid recipient]	<div> <div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div> </div>		
8. REASONS FOR ASSESSMENT	[Note—Other codes do not apply to this form] a. Primary reason for assessment 1. Initial assessment 2. Annual assessment 3. Significant change in status assessment		<div> <div></div><div></div> </div>



SECTION A. IDENTIFICATION AND BACKGROUND INFORMATION

A1.	INDIVIDUAL				
		a. (First)	b. (Middle Initial)	c. (Last)	d. (Jr/Sr)
A2.	ROOM NUMBER	<div> <div></div> <div></div> <div></div> <div></div> <div></div> </div>			
A3.	ASSESSMENT REFERENCE DATE	a. Last day of observation period <div> <div></div> <div></div> </div> <div> <div></div> <div></div> </div> <div> <div></div> <div></div> <div></div> <div></div> </div> <div>Month</div> <div>Day</div> <div>Year</div>			
A4a.	DATE OF MOST RECENT HOSPITALIZATION	Date of most recent hospitalization discharge in last 90 days  <div> <div></div> <div></div> </div> <div> <div></div> <div></div> </div> <div> <div></div> <div></div> <div></div> <div></div> </div> <div>Month</div> <div>Day</div> <div>Year</div>			

SECTION B. COGNITIVE PATTERNS

B1.	COMATOSE	(Persistent vegetative state/no discernible consciousness) 0. No 1. Yes <b>(Skip to Section G)</b>	
B2.	MEMORY	(Recall of what was learned or known)  a. Short-term memory OK- seems/appears to recall 0. Memory OK 1. Memory problem  b. Long-term memory OK—seems/appears to recall long past events 0. Memory OK 1. Memory problem	
B3.	MEMORY/ RECALL ABILITY	(Check all that individual was normally able to recall during last 30 days) Current season <div>a.</div> Location of own room <div>b.</div> That he/she is in own home /room <div>d.</div> Caregiver/family names <div>c.</div> NONE OF ABOVE are recalled <div>e.</div>	
B4.	COGNITIVE SKILLS FOR DAILY DECISION- MAKING	(Made decisions regarding tasks of daily life)  0. INDEPENDENT—decisions consistent/reasonable 1. MODIFIED INDEPENDENCE—some difficulty in new situations only 2. MODERATELY IMPAIRED—decisions poor; cues/supervision required 3. SEVERELY IMPAIRED—never/rarely made decisions	
B5.	INDICATORS OF DELIRIUM— PERIODIC DISOR- DERED THINKING/ AWARENESS	(Code for behavior in the last 30 days.) [Note: Accurate assessment requires conversations with caregiver/family who have direct knowledge of individual's behavior over this time].  0. Behavior not present 1. Behavior present, not of recent onset 2. Behavior present, over last 30 days appears different from individual's usual functioning (e.g., new onset or worsening)  a. EASILY DISTRACTED—(e.g., difficulty paying attention; gets sidetracked)  b. PERIODS OF ALTERED PERCEPTION OR AWARENESS OF SURROUNDINGS—(e.g., moves lips or talks to someone not present; believes he/she is somewhere else; confuses night and day)  c. EPISODES OF DISORGANIZED SPEECH—(e.g., speech is incoherent, nonsensical, irrelevant, or rambling from subject to subject; loses train of thought)  d. PERIODS OF RESTLESSNESS—(e.g., fidgeting or picking at skin, clothing, napkins, etc; frequent position changes; repetitive physical movements or calling out)  e. PERIODS OF LETHARGY—(e.g., sluggishness; staring into space; difficult to arouse; little body movement)  f. MENTAL FUNCTION VARIES OVER THE COURSE OF THE DAY—(e.g., sometimes better, sometimes worse; behaviors sometimes present, sometimes not)	

SECTION C. COMMUNICATION/HEARING PATTERNS

C1.	HEARING	(With hearing appliance, if used)  0. HEARS ADEQUATELY—normal talk, TV, phone 1. MINIMAL DIFFICULTY when not in quiet setting 2. HEARS IN SPECIAL SITUATIONS ONLY—speaker has to adjust tonal quality and speak distinctly 3. HIGHLY IMPAIRED/ absence of useful hearing	
C2.	COMMUNI- CATION DEVICES/ TECH- Niques	(Check all that apply during last 30 days) Hearing aid, present and used <div>a.</div> Hearing aid, present and not used regularly <div>b.</div> Other receptive comm. techniques used (e.g., lip reading) <div>c.</div> NONE OF ABOVE <div>d.</div>	
C3.	MODES OF EXPRESSION	(Check all used by Individual to make needs known) Speech <div>a.</div> Writing messages to express or clarify needs <div>b.</div> American sign language or Braille <div>c.</div> Signs/ Gestures/ Sounds <div>d.</div> Communication Board <div>e.</div> Other <div>f.</div> Voice Modulator <div>h.</div> NONE OF ABOVE <div>g.</div>	

C4.	MAKING SELF UNDER- STOOD	(Expressing information content—however able)  0. UNDERSTOOD 1. USUALLY UNDERSTOOD—difficulty finding words or finishing thoughts 2. SOMETIMES UNDERSTOOD—ability is limited to making concrete requests 3. RARELY/NEVER UNDERSTOOD	
C6.	ABILITY TO UNDER- STAND OTHERS	(Understanding verbal information content—however able)  0. UNDERSTANDS 1. USUALLY UNDERSTANDS—may miss some part/intent of message 2. SOMETIMES UNDERSTANDS—responds adequately to simple, direct communication 3. RARELY/NEVER UNDERSTANDS	

SECTION D. VISION PATTERNS

D1.	VISION	(Ability to see in adequate light and with glasses if used)  0. ADEQUATE—sees fine detail, including regular print in newspapers/books 1. IMPAIRED—sees large print, but not regular print in newspapers/ books 2. MODERATELY IMPAIRED—limited vision; not able to see newspaper headlines, but can identify objects 3. HIGHLY IMPAIRED—object identification in question, but eyes appear to follow objects 4. SEVERELY IMPAIRED—no vision or sees only light, colors, or shapes; eyes do not appear to follow objects	
D2.	VISUAL LIMITATIONS/ DIFFICULTIES	Side vision problems—decreased peripheral vision (e.g., leaves food on one side of tray, difficulty traveling, bumps into people and objects, misjudges placement of chair when seating self)  Experiences any of following: sees halos or rings around lights; sees flashes of light; sees "curtains" over eyes  NONE OF ABOVE	<div>a.</div> <div>b.</div> <div>c.</div>
D3.	VISUAL APPLIANCES	0. Glasses; contact lenses; magnifying glass 1. Yes	

SECTION E. MOOD AND BEHAVIOR PATTERNS

E1.	INDICATORS OF DEPRES- SION, ANXIETY, SAD MOOD	(Code for indicators observed in last 30 days, irrespective of the assumed cause) 0. Indicator not exhibited in last 30 days 1. Indicator of this type exhibited up to five days a week 2. Indicator of this type exhibited daily or almost daily (6, 7 days a week)  <b>VERBAL EXPRESSIONS OF DISTRESS</b>  a. Individual made negative statements—e.g., "Nothing matters; Would rather be dead; What's the use; Regrets having lived so long; Let me die"  b. Repetitive questions—e.g., "Where do I go; What do I do?"  c. Repetitive verbalizations—e.g., calling out for help, ("God help me")  d. Persistent anger with self or others—e.g., easily annoyed.  e. Self deprecation—e.g., "I am nothing; I am of no use to anyone"  f. Expressions of what appear to be unrealistic fears—e.g., fear of being abandoned, left alone, being with others  g. Recurrent statements that something terrible is about to happen—e.g., believes he or she is about to die, have a heart attack  <b>h. Repetitive health complaints—e.g., persistently seeks medical attention, obsessive concern with body functions</b>  <b>i. Repetitive anxious complaints/concerns (non- health related) e.g., persistently seeks attention/ reassurance regarding schedules, meals, laundry, clothing, relationship issues</b>  <b>SLEEP-CYCLE ISSUES</b>  <b>j. Unpleasant mood in morning</b>  <b>k. Insomnia/change in usual sleep pattern</b>  <b>SAD, APATHETIC, ANXIOUS APPEARANCE</b>  <b>l. Sad, pained, worried facial expressions—e.g., furrowed brows</b>  <b>m. Crying, tearfulness</b>  <b>n. Repetitive physical movements—e.g., pacing, hand wringing, restlessness, fidgeting, picking</b>  <b>LOSS OF INTEREST</b>  <b>o. Withdrawal from activities of interest—e.g., no interest in long standing activities or being with family/friends</b>  <b>p. Reduced social interaction</b>	
E2.	MOOD PERSIS- TENCE	One or more indicators of depressed, sad or anxious mood were not easily altered by attempts to "cheer up", console, or reassure the individual over last 30 days 0. No mood indicators 1. Indicators present, easily altered 2. Indicators present, not easily altered	
E3.	CHANGE IN MOOD	Individual's mood status has changed as compared to status of 30 days ago (or since last assessment if less than 30 days) 0. No change 1. Improved 2. Deteriorated	

E4.	<b>BEHAVIORAL SYMPTOMS</b>	(A) <i>Behavioral symptom frequency in last 7 days</i> 0. Behavior not exhibited in last 7 days 1. Behavior of this type occurred 1 to 3 days in last 7 days 2. Behavior of this type occurred 4 to 6 days, but less than daily 3. Behavior of this type occurred daily	(A)	(B)
		(B) <i>Behavioral symptom alterability in last 7 days</i> 0. Behavior not present OR behavior was easily altered 1. Behavior was not easily altered		
		a. WANDERING (moved with no rational purpose, seemingly oblivious to needs or safety)		
		b. VERBALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were threatened, screamed at, cursed at)		
		c. PHYSICALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were hit, shoved, scratched, sexually abused)		
		d. SOCIALLY INAPPROPRIATE/DISRUPTIVE BEHAVIORAL SYMPTOMS (made disruptive sounds, noisiness, screaming, self-abusive acts, sexual behavior or disrobing in public, smeared/threw food/feces, hoarding, rummaged through others' belongings)		
		e. RESISTS CARE (resisted taking medications/ injections, ADL assistance, or eating)		

## SECTION G. PHYSICAL FUNCTIONING AND STRUCTURAL PROBLEMS

G1.	(A) <b>ADL SELF-PERFORMANCE</b> —(Code for individual performance over a 24 hr period during last 30 days—Not including setup)	0. <i>INDEPENDENT</i> —No help or oversight —OR— Help/oversight provided only 1 or 2 times during last 30 days	(A)	(B)
		1. <i>SUPERVISION</i> —Oversight, encouragement or cueing provided 3 or more times during last 30 days —OR— Supervision (3 or more times) plus physical assistance provided only 1 or 2 times during last 30 days		
		2. <i>LIMITED ASSISTANCE</i> —Individual highly involved in activity; received physical help in guided maneuvering of limbs or other nonweight bearing assistance 3 or more times —OR— More help provided only 1 or 2 times during last 30 days		
		3. <i>EXTENSIVE ASSISTANCE</i> —While individual performed part of activity, over last 30-day period, help of following type(s) provided 3 or more times: —Weight-bearing support —Full staff performance during part (but not all) of last 30 days		
		4. <i>TOTAL DEPENDENCE</i> —Full staff performance of activity during entire 30 days		
		8. <i>ACTIVITY DID NOT OCCUR</i> during entire 30 days		
	(B) <b>ADL SUPPORT PROVIDED</b> —(Code for MOST SUPPORT PROVIDED OVER A 24 hr period during last 30 days; code regardless of Individual's self-performance classification)	0. No setup or physical help from staff	SELF-PERF	SUPPORT
		1. Setup help only		
		2. One person physical assist		
		3. Two+ persons physical assist		
		8. ADL activity itself did not occur during entire 30 days		
a.	<b>BED MOBILITY</b>	How individual moves to and from lying position, turns side to side, and positions body while in bed		
b.	<b>TRANSFER</b>	How individual moves between surfaces—to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet)		
c.	<b>WALK IN ROOM</b>	How individual walks between locations in room		
d.	<b>WALK IN HOME</b>	How individual walks in home or community setting.		
e.	<b>LOCOMOTION IN ROOM</b>	How individual moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair		
f.	<b>LOCOMOTION IN HOME</b>	How individual moves to and returns from distant areas in his/her home or community setting. If in wheelchair, self-sufficiency once in chair		
g.	<b>DRESSING</b>	How individual puts on, fastens, and takes off all items of <b>street clothing</b> , including donning/removing prosthesis		
h.	<b>EATING</b>	How individual eats and drinks (regardless of skill) including intake of nourishment by other means (e.g. tube feeding, total parenteral nutrition).		
i.	<b>TOILET USE</b>	How individual uses the toilet room (or commode, bedpan, urinal); transfer on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes		
j.	<b>PERSONAL HYGIENE</b>	How individual maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands, and perineum (EXCLUDE baths and showers)		
G2.	<b>BATHING</b>	How individual takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (EXCLUDE washing of back and hair.) <b>Code for most dependent in self-performance.</b> (A) BATHING SELF PERFORMANCE codes appear below (B) ADL SUPPORT PROVIDED	(A)	(B)
		0. Independent- No help provided		
		1. Supervision— Oversight help only		
		2. Physical help limited to transfer only		
		3. Physical help in part of bathing activity		
		4. Total dependence		
		8. Activity itself did not occur during entire 30 days		

G3.	<b>MAINTAIN BALANCE</b>	(Code for ability in the last 30 days) 0. Maintained position as required 1. Unsteady, but able to rebalance self without physical support 2. Partial physical support required; or stands (sits) but does not follow directions 3. Not able to attempt balance without physical help	(A)	(B)
		a. Balance while standing b. Balance while sitting—position, trunk control		
G4.	<b>FUNCTIONAL LIMITATION IN RANGE OF MOTION</b>	(Code for limitations during last 30 days that interfered with daily functions or placed individual at risk of injury) (A) <i>RANGE OF MOTION</i> 0. No limitation 1. Limitation on one side 2. Limitation on both sides	(A)	(B)
		(B) <i>VOLUNTARY MOVEMENT</i> 0. No loss 1. Partial loss 2. Full loss		
		a. Neck		
		b. Arm—including shoulder or elbow		
		c. Hand—including wrist or fingers		
		d. Leg—including hip or knee		
G6.	<b>MODES OF TRANSFER</b>	(Check all that apply during last 30 days) Bedfast all or most of time Bed rails used for bed mobility or transfer	NONE OF ABOVE	f.
		a.		
		b.		

## SECTION H. CONTINENCE IN LAST 30 DAYS

H1.	<b>CONTINENCE SELF-CONTROL CATEGORIES</b> (Code for Individual's PERFORMANCE OVER A 24 hr period in last 30 days)	0. <i>CONTINENT</i> —Complete control [includes use of indwelling urinary catheter or ostomy device that does not leak urine or stool]	(A)	(B)
		1. <i>USUALLY CONTINENT</i> —BLADDER, incontinent episodes once a week or less; BOWEL, less than weekly		
		2. <i>OCCASIONALLY INCONTINENT</i> —BLADDER, 2 or more times a week but not daily; BOWEL, once a week		
		3. <i>FREQUENTLY INCONTINENT</i> —BLADDER, tended to be incontinent daily, but some control present (e.g., on day shift); BOWEL, 2-3 times a week		
		4. <i>INCONTINENT</i> —Had inadequate control BLADDER, multiple daily episodes; BOWEL, all (or almost all) of the time		
a.	<b>BOWEL CONTINENCE</b>	Control of bowel movement, with appliance or bowel continence programs, if employed		
b.	<b>BLADDER CONTINENCE</b>	Control of urinary bladder function (if dribbles, volume insufficient to soak through underpants), with appliances (e.g., foley) or continence programs, if employed		
H2.	<b>BOWEL ELIMINATION PATTERN</b>	Constipation	b.	Diarrhea
		Fecal Impaction	d.	NONE OF ABOVE
H3.	<b>APPLIANCES AND PROGRAMS</b>	Any scheduled toileting plan	a.	Indwelling catheter
		Bladder retraining program	b.	Ostomy present
		External (condom) catheter	c.	NONE OF ABOVE

## SECTION J. HEALTH CONDITIONS

J1.	PROBLEM CONDITIONS	(Check all problems present in last 7 days unless other time frame is indicated)
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J1.	PROBLEM CONDITIONS	(Check all problems present in last 7 days unless other time frame is indicated)		f. g. h. i. j. k. l. m. n. o. p.	
		INDICATORS OF FLUID STATUS  Weight gain or loss of 3 or more pounds within a 7 day period  Inability to lie flat due to shortness of breath  Dehydrated; output exceeds input  Insufficient fluid; did <b>NOT</b> consume all/almost all liquids provided during <b>last 3 days</b>  <b>OTHER</b>  Delusions	a. b. c. d. e.		Dizziness/Vertigo
					Edema
					Fever
					Hallucinations
					Internal bleeding
					Recurrent lung aspirations in <b>last 90 days</b>
					Shortness of breath
					Syncope (fainting)
					Unsteady gait
Vomiting					
NONE OF ABOVE					
J2.	PAIN SYMPTOMS	(Code the <i>highest level of pain</i> present in the <b>last 30 days</b> )			
J4.	ACCIDENTS	(Check all that apply) Fell in <b>past 30 days</b>  Fell in <b>past 31-180 days</b>	a. b.	<b>a. FREQUENCY</b> with which individual complains or shows evidence of pain  0. No pain ( <b>skip to J4</b> ) 1. Pain less than daily 2. Pain daily	<b>b. INTENSITY</b> of pain  1. Mild pain 2. Moderate pain 3. Times when pain is horrible or excruciating
				Hip fracture in <b>last 180 days</b>	
				Other fracture in <b>last 180 days</b>	
J5.	STABILITY OF CONDITIONS	Conditions/diseases make individual's cognitive, ADL, mood or behavior status unstable—(fluctuating, precarious, or deteriorating)  Individual experiencing an acute episode or a flare-up of a recurrent or chronic problem  End-stage disease, 6 or fewer months to live  NONE OF ABOVE	a. b. c. d.	NONE OF ABOVE	

K1.	ORAL PROBLEMS	Chewing problem Swallowing problem <b>NONE OF ABOVE</b>						a. b. d.				
K2.	HEIGHT AND WEIGHT	Record(a.) height in inches and (b.) weight in pounds. Base weight on most recent measure in last 30 days										
								a. HT (in.)		b. WT (lb.)		
K3.	WEIGHT CHANGE	a. Weight loss—5 % or more in last 30 days; or 10% or more in the last 180 days 0. No                      1. Yes										
		b. Weight gain—5 % or more in last 30 days; or 10 % or more in last 180 days 0. No                      1. Yes										
K5.	NUTRITIONAL APPROACH - ES	Parenteral /IV  Feeding tube  Dietary supplement between meals		a.	On a planned weight change program			h.				
				b.	Therapeutic diet			e.				
				f.	NONE OF ABOVE			i.				
K6.	PARENTERAL OR ENTERAL INTAKE	(Skip to Section M if neither 5a nor 5b is checked)										
		a. Code the proportion of total calories the Individual received through parenteral or tube feedings in the last 30 days 0. None                      3. 51% to 75% 1. 1% to 25%                  4. 76% to 100% 2. 26% to 50%										
		b. Code the average fluid intake per day by IV or tube in last 30 days 0. None                      3. 1001 to 1500 cc/day 1. 1 to 500 cc/day        4. 1501 to 2000 cc/day 2. 501 to 1000 cc/day    5. 2001 or more cc/day										

M1.	<b>ULCERS</b>  <b>(Due to any cause)</b>	<i>(Record the number of ulcers at each ulcer stage—regardless of cause. If none present at a stage, record "0" (zero). Code all that apply during last 30 days. Code 9 = 9 or more.</i>	Number at Stage
		a. Stage 1. A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved.	
		b. Stage 2. A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater.	
		c. Stage 3. A full thickness of skin is lost, exposing the subcutaneous tissues - presents as a deep crater with or without undermining adjacent tissue.	
		d. Stage 4. A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.	
M2.	<b>TYPE OF ULCER</b>	<i>(For each type of ulcer, code for the highest stage in the last 30 days using scale in item M1—i.e., 0=none; stages 1, 2, 3, 4)</i>	
		a. Pressure ulcer—any lesion caused by pressure resulting in damage of underlying tissue	
		b. Stasis ulcer—open lesion caused by poor circulation in the lower extremities	

<b>M4. OTHER SKIN PROBLEMS OR LESIONS PRESENT</b>  (Check all that apply during last 30 days)	Abrasions, bruises	a.	
	Burns (second or third degree)	b.	
	Open lesions other than ulcers, rashes, cuts (e.g., cancer lesions)	c.	
	Rashes—e.g., intertrigo, eczema, drug rash, heat rash, herpes zoster	d.	
	Skin desensitized to pain or pressure	e.	
	Skin tears or cuts (other than surgery)	f.	
	Surgical wounds	g.	
	NONE OF ABOVE	h.	
<b>M5. SKIN TREATMENTS</b>  (Check all that apply during last 30 days)	Pressure relieving device(s) for chair	a.	
	Pressure relieving device(s) for bed	b.	
	Turning/repositioning program	c.	
	Nutrition or hydration intervention to manage skin problems	d.	
	Ulcer care	e.	
	Surgical wound care	f.	
	Application of dressings (with or without topical medications) other than to feet	g.	
	Application of ointments/medications (other than to feet)	h.	
	Other preventative or protective skin care (other than to feet)	i.	
	NONE OF ABOVE	j.	
	<b>M6. FOOT PROBLEMS AND CARE</b>  (Check all that apply during last 30 days)	Individual has one or more foot problems—e.g., corns, callouses, bunions, hammer toes, overlapping toes, pain, structural problems	a.
		Infection of the foot—e.g., cellulitis, purulent drainage	b.
Open lesions on the foot		c.	
Nails/calluses trimmed during last 90 days		d.	
Received preventative or protective foot care (e.g., used special shoes, inserts, pads, toe separators)		e.	
Application of dressings (with or without topical medications)		f.	
NONE OF ABOVE		g.	

## SECTION N. ACTIVITY PURSUIT PATTERNS

<b>N1. TIME AWAKE</b>	(Check appropriate time periods over last 30 days)	
	Individual awake all or most of time (i.e., naps no more than one hour per time period) in the:	
	Morning <input type="checkbox"/> Evening <input type="checkbox"/>	c.
	Afternoon <input type="checkbox"/> NONE OF ABOVE <input type="checkbox"/>	d.
(If Individual is comatose, skip to Section O)		
<b>N2. AVERAGE TIME INVOLVED IN ACTIVITIES</b>	(When awake and not receiving treatments or ADL care)	
	0. Most—more than 2/3 of time	2. Little—less than 1/3 of time
	1. Some—from 1/3 to 2/3 of time	3. None

## SECTION O. MEDICATIONS

<b>O1. NUMBER OF MEDICATIONS</b>	(Record the number of different medications used in the last 30 days; enter "0" if none used)	
<b>O3. INJECTIONS</b>	(Record the number of DAYS injections of any type received during the last 7 days; enter "0" if none used)	
<b>O4. DAYS RECEIVED THE FOLLOWING MEDICATION</b>	(Record the number of DAYS during last 7 days; enter "0" if not used. Note—enter "1" for long-acting meds used less than weekly)	
	a. Antipsychotic <input type="checkbox"/>	d. Hypnotic <input type="checkbox"/>
	b. Antianxiety <input type="checkbox"/>	e. Diuretic <input type="checkbox"/>
	c. Antidepressant <input type="checkbox"/>	

## SECTION P. SPECIAL TREATMENTS AND PROCEDURES

<b>P1. SPECIAL TREATMENTS, PROCEDURES, AND PROGRAMS</b>	<b>a. SPECIAL CARE</b> —Check treatments or programs received during the last 30 days	
	<b>TREATMENTS</b>	
	Chemotherapy <input type="checkbox"/>	Ventilator or respirator <input type="checkbox"/>
	Dialysis <input type="checkbox"/>	<b>PROGRAMS</b>
	IV medication <input type="checkbox"/>	Alcohol/drug treatment program <input type="checkbox"/>
	Intake/output <input type="checkbox"/>	Alzheimer's/dementia special care unit <input type="checkbox"/>
	Monitoring acute medical condition <input type="checkbox"/>	Hospice care <input type="checkbox"/>
	Ostomy care <input type="checkbox"/>	Pediatric unit <input type="checkbox"/>
	Oxygen therapy <input type="checkbox"/>	Respite care <input type="checkbox"/>
	Radiation <input type="checkbox"/>	Training in skills required to return to the community (e.g., taking medications, house work, shopping, transportation, ADLs) <input type="checkbox"/>
	Suctioning <input type="checkbox"/>	Psychiatric care <input type="checkbox"/>
	Tracheostomy care <input type="checkbox"/>	NONE OF ABOVE <input type="checkbox"/>
	Transfusions <input type="checkbox"/>	
	a. 1. Number of Psychiatric hospitalizations in the last year	
	b. <b>THERAPIES</b> —Record the number of days and total minutes each of the following therapies was administered (for at least 15 min a day) in the last 7 calendar days (Enter 0 if none or less than 15 min daily)	
[Note- Count only post admission therapies]		
(A) = # of days administered for 15 min or more	DAYS (A)	
(B) = total # of minutes provided in last 7 days	MIN (B)	
a. Speech - language pathology and audiology services		
b. Occupational therapy		
c. Physical therapy		
d. Respiratory therapy		
e. Psychological therapy (by any licensed mental health professional)		
<b>P3. NURSING REHABILITATION/ RESTORATIVE CARE</b>	Record the NUMBER OF DAYS each of the following rehabilitation or restorative techniques or practices was provided to the Individual for more than or equal to 15 minutes per day in the last 7 days (Enter 0 if none or less than 15 min. daily.)	
	a. Range of motion (passive)	f. Walking
	b. Range of motion (active)	g. Dressing or grooming
	c. Splint or brace assistance	h. Eating or swallowing
	<b>TRAINING AND SKILL PRACTICE IN:</b>	i. Amputation/prosthesis care
	d. Bed mobility	j. Communication
	e. Transfer	k. Other
	<b>P4. DEVICES AND RESTRAINTS</b>	Use the following codes for last 30 days:
	0. Not used	
	1. Used less than daily	
2. Used daily		
	Bed rails	
a. Full bed rails on all open sides of bed		
b. Other types of side rails used (e.g., half rail, one side)		
c. Trunk restraint		
d. Limb restraint		
e. Chair prevents rising		
<b>P7. PHYSICIAN VISITS</b>	In the LAST 14 DAYS (or since admission if less than 14 days in Program) how many days has the physician (or authorized assistant or practitioner) examined the Individual? Enter 0 if none	
<b>P8. PHYSICIAN ORDERS</b>	In the LAST 14 DAYS (or since admission if less than 14 days in Program) how many days has the physician (or authorized assistant or practitioner) changed the Individual's orders? Do not include order renewals without change. (Enter 0 if none)	

## SECTION Q. DISCHARGE POTENTIAL AND OVERALL STATUS

<b>Q2. OVERALL CHANGE IN CARE NEEDS</b>	Individual overall level of self sufficiency has changed significantly as compared to status of 90 days ago (or since last assessment if less than 90 days)	
	0. No change	1. Improved—receives fewer supports, needs less restrictive level of care
		2. Deteriorated—receives more support

## SECTION R. SIGNATURE / DATE COMPLETED

## R2. SIGNATURE OF PERSON COORDINATING THE ASSESSMENT:

a. Signature of RN completing assessment (sign on above line)
b. Date Assessment Completed
<div style="display: flex; align-items: center; justify-content: center;"> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="margin: 0 5px;">—</div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="margin: 0 5px;">—</div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> </div> <div style="display: flex; justify-content: space-around; margin-top: 5px;"> <span>Month</span> <span>Day</span> <span>Year</span> </div>

[illegible]

Individual Name \_\_\_\_\_

Numeric Identifier \_\_\_\_\_

**LTC Medicaid Information****S1. Medicaid Information**

S1a.	Medicaid Client Indicator 1. Medicaid	
S1b.	Admission to Medicaid Date	
S1c.	Admitted from 1. Home 2. Hospital 3. Nursing Facility 4. State School/Facility 5. Other 6. Cannot Determine	
S1d.	Individual Address	
S1e.	City	
S1f.	State	
S1g.	Zip Code	

**S2. Claims Processing Information**

S2a.	DADS Vendor/Site ID	
S2b.	Contract/Provider Number	
S2c.	Service Group	
S2d.	NPI Number	
S2e.	Region	
S2f.	Purpose Code	

**S3. Primary Diagnosis**

S3a.	Primary Diagnosis ICD-9	
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**S4. For DADS use only**

S4a.	MN	
S4b.	RUG	
S4c.	Effective Date	
S4d.	Expiration Date	
S4e.	County	
S4f.	DADS RN Signature	
S4g.	Signature Date	

**S5. Licenses**

Provider certification: I certify to the completeness of this information

S5a.	DADS RN Last Name	
S5b.	DADS RN License #	
S5b1.	DADS RN License State	
S5c.	HHA RN Last Name	
S5d.	HHA RN License #	
S5d1.	HHA RN License State	
S5e.	DADS UR RN Last Name	
S5f.	DADS UR RN License #	
S5f1.	DADS UR RN License State	
S5g.	DADS UR RN Signature Date	
DADS UR RN Signature		
S5h.	PACE RN Last name	
S5i.	PACE License #	
S5i1.	PACE RN License State	
S5j.	HMO RN Last Name	
S5k.	HMO RN License #	
S5k1.	HMO RN License State	

**S6. Therapeutic Intervention**

S6a.	Tracheostomy Care	
S6b.	Ventilator/Respirator	

**S7. Physician's Evaluation & Recommendation**

S7a.	I certify that this individual requires nursing facility services or alternative community based services under supervision of an MD/DO. Y/N	
S7b.	MD/DO Last Name	
S7c.	MD/DO License #	
S7c1.	MD/DO License state	
S7d.	MD/DO Military Spec Code	
S7e.	Physician's Signature on File	<div>(Required for Initial Assessments)</div> <div></div>

Individual Name: \_\_\_\_\_ Numeric Identifier: \_\_\_\_\_

**LTC Medicaid Information**

**S8. Comments**

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**MEDICAL NECESSITY AND LEVEL OF CARE ASSESSMENT**  
**PHYSICIAN'S SIGNATURE**

Name:

SSN:

DOB: 1/1/0001

**Primary Diagnosis** (ICD-9 Code – Diagnosis Description):

**Diseases:**

**Other Diagnoses:**

**I certify that this individual requires nursing facility services or alternative community based services under supervision of an MD/DO.**

**X** \_\_\_\_\_

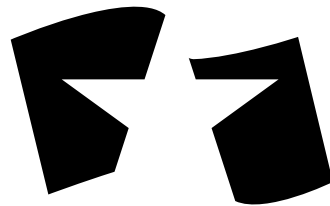
\_\_\_\_\_  
**Date**











**TMHP**

**TEXAS MEDICAID**

**&**  
**HEALTHCARE PARTNERSHIP**

**A STATE MEDICAID CONTRACTOR**